AN EXPLORATION OF HOW HEALTHFUL RELATIONSHIPS BETWEEN STUDENTS AND CLINICAL SUPERVISORS INFLUENCE TRANSFORMATIONAL LEARNING: A PERSON-CENTRED INQUIRY

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Abstract

Background: There is an emerging body of knowledge regarding the influence of person-centred pre-registration curricula on student learning. However, a gap exists in our current knowledge regarding the attributes and foundations of healthful relationships and transformational learning in the context of practice learning. This PhD research based at the University of Wollongong NSW Australia, explored how healthful relationships between students and clinical supervisors influence transformational learning.

Approach and Method: The blending of specific aspects of critical theory, person-centred practice research, and transformational learning theory underpinned this research. Embedded within a person-centred methodology, the research explored healthful relationships and their influence on transformational learning in the clinical practice context. Methods included reflection on practice using emoji, the use of Dadirri as a form of contemplation (Ungunmerr 1988) and reflection, critical dialogue and interviews. A creative synthesis of information collected across the PhD journey was undertaken.

Findings: The findings from this research revealed the influence of healthful relationships on transformational learning in practice across three connected perspectives: personhood; belonging; and transformation. Information was synthesised to illuminate the crafting of healthful relationships between students and clinical supervisors in the context of practice. Further, understanding emerged of how healthful relationships influenced person-centred transformational learning from the perspectives of Knowing, Doing, Being and Becoming. The discoveries indicate that emotional preparation influences the ability to create healthful relationships that enable person-centred transformational learning in practice.

Conclusions and Implications: There is a need for emotional preparation for practice for students and clinical supervisors to enable them to achieve person-centred transformational learning. Respecting personhood and enabling belonging to know self has the potential to lead to the creation of healthful relationships and improved clinical placement experience. Healthful relationships influence person-centred transformational learning by enabling an emotional connection of the mind and heart with an openness to learn.

Keywords:
curricula, Dadirri, emoji, healthful relationships, nursing education, person-centred, transformational learning.

Dedication

I dedicate this thesis to my husband, Steven.
You have been my rock throughout this journey.
Thank you for sacrificing time with me so I could achieve my dream.
Your support has helped me have the courage to achieve something that I was not sure I was capable of.

Acknowledgements

My PhD journey began in 2015, and I feel very privileged to have been able to be a PhD candidate at Queen Margaret University. My mother, who is no longer here with us, travelled from Australia to Scotland with me to enrol and that is a memory that I will always cherish. I know she would be proud of me for reaching the end of the journey.

I have been fortunate to have three supervisors who have supported and mentored me as I moved along my journey and I will be forever grateful for the patience and kindness they have shown to me. Thank you to Professor Jan Dewing, who has been my primary supervisor. I would not have been able to complete this PhD without your belief in me, for that I will always be grateful. You encouraged me to keep going through the good and tough times. I can remember meeting you at Wollongong University, Australia, and at that time, some nine years ago, the thought then of being able to undertake my PhD with you as my supervisor was just a dream. I am so grateful that you encouraged me to enrol at Queen Margaret University and for the kindness and friendship you have shown to me. You are such a wonderful role model in how you craft healthful relationships with all of your PhD students. Thank you for your honesty and for challenging me to seek my full potential on this journey.

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and encouragement for me to complete this PhD research. Your friendship and belief in me means a lot and has inspired me to stay true to myself.

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To the wonderful students and clinical supervisors who were participants and co-researchers in this PhD research, I would like to sincerely thank you for sharing your wisdom and time with me. I value your authenticity, courage and honesty. I will be forever grateful to each one of you for agreeing to participate in this PhD research, I have learnt so much from you. Many challenges arose throughout the information collection and synthesis, their ability to rise above this and bring such enthusiasm was something I remain in awe of. My heartfelt thanks to each of you, I hope you appreciate the amazing contribution you have made to this PhD research.

To my family, thank you for giving me your blessings to undertake my PhD. My children, Kimberley, Thomas and Jacinta, my grandchildren, Sasha, Ava and Lachlan and my sister, Tracey, you have all been with me through this journey and have sacrificed time with me so I could achieve my dream.

My final heartfelt thank you is to my husband Steven Mackay, thank you for loving me and always believing that I could do this. I am in looking forward to the next part of our journey together. I promise I am now finished studying.

Maria

Contents

List of Tables and Images

Abbreviations

ANMAC	Australian Nursing and Midwifery Accreditation Council
BN	Bachelor of Nursing
CATSINaM	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
CRD	Centre for Reviews and Dissemination
DCL	Director of Clinical Learning
FoR	Facilitation on the Run (Hardiman and Dewing 2019)
HETI	Health Education Training Institute
HREC	Human Research Ethics Committee
NMBA	Nursing Midwifery Board of Australia
NSW	New South Wales (Australia)
NSW Health	New South Wales Health
SICOP	Student International Community of Practice
SN	School of Nursing
SNUG 104	Year 1 BN subject School of Nursing Under Graduate (SNUG) 104
SNUG108	Year 1 BN subject School of Nursing Under Graduate (SNUG) 108
UOW	University of Wollongong

Chapter 1

Introduction To My PhD Journey

Image 1-1 My PhD Journey-© Maria Mackay 2020

Introduction to the Thesis

The image above (see Image 1-1) is a picture of the original painting that was completed by a friend and illustrates my PhD journey. The painting is owned by me and I have permission to use this in my PhD from the artist and my friend Gaye Sykes. It is presented here in its entirety and can be seen again at the beginning of each of the following chapters, where parts of this painting are reintroduced to show my journey within this thesis. The entire painting is shown again when I bring the thesis to a close and share my key discoveries unearthed in collaboration with participants and co-researchers to show how the road travelled has been transformative for me in discovering myself as a person-centred novice researcher. The painting has many aspects to it and as you delve deeper into it throughout each chapter, some of the hidden meanings are revealed. I feel for me, this painting brings together the privilege I have of being an Australian Aboriginal nurse and academic along with the wonderful journey I have experienced whilst a student at Queen Margaret University in Edinburgh, Scotland. I feel my culture, my home,

my profession and my PhD have been blended beautifully into this piece of art. There are imperfections in the painting, such as the words patient-centred instead of person-centred, I have purposefully chosen to keep the painting as it was created and not have changes made. It originated from a dialogue (Habermas 1987; Mezirow 2000) I had with my friend and she developed this from our conversation and therefore, I believe this is an authentic representation of my PhD journey.

In the beginning of my PhD journey, I purposefully chose to enrol at Queen Margaret University, Edinburgh for two main reasons. Firstly, I wished to undertake a PhD embedded in person-centred practice research. Secondly, I believe as an academic staff member, it was better for my learning to complete my PhD at a different university to where I work, providing me with the opportunity to be a student rather than a senior lecturer. At the commencement of my PhD, many people provided advice from their personal experience. I heard over and over from colleagues who had completed their PhD that your topic will change as you grow as a PhD researcher. I thought to myself, that will not be me, I am passionate about and committed to my topic, it will not change. Over the last five years, the reality is that the advice I was given was correct and my experience was no different from anyone else who takes this journey. I began focusing on how to empower clinical supervisors to facilitate the learning of students in practice from a strengths-based perspective. However, I soon realised that the focus needed to be on both students and clinical supervisors equally if my study was to be grounded in a person-centred perspective. I have changed how I see and understand the world from the experience of undertaking this PhD journey.

The PhD research question, aims and objectives are described below, and these are further explored in Chapter 5, following the review of the exploratory phase of the research and literature reviews.

Research title

An exploration of how healthful relationships between students and clinical supervisors influence transformational learning: a person-centred inquiry.

Research question

How do healthful relationships between students and clinical supervisors influence transformational learning?

Aims

This research aims to:

- Understand what a healthful relationship between students and clinical supervisors looks like and feels like.
- Explore how healthful relationships between students and clinical supervisors influence transformational learning in clinical practice.
- Explore if healthful relationships between students and clinical supervisors to the development of person-centred learning cultures in clinical practice.

Objectives

The Objectives of this PhD research are to:

- Contribute to the person-centred knowledge base about the preparation of students' and clinical supervisors' practice, specifically the development of healthful relationships
- Contribute to the person-centred knowledge base, specifically about the development of person-centred education curricula at UOW and wider in Australia
- Contribute to the transformational learning knowledge base specifically within a clinical non-classroom setting.

Overview of the Chapters

In Chapter 1, I introduce the painting that creatively represents my PhD journey. I also include an outline of my research topic, question, aims and objectives. In Chapter 2, I describe how and why it is significant to explore healthful relationships between students and clinical supervisors and the influence on transformational learning. I present how I have considered the language I used to describe participants and co-researchers in the PhD research and conclude with an overview of the research context. I then move to Chapter 3, which is where I explore my personal ontology and share

how I have come to see the world through my life journey to date. I have used Kockelman's (2013) analogy of a piece of fabric, which through the soils and stains, represents the sum total of who we are. I have explored the threads that make the fabric and exposed the knots and frays that have influenced me throughout my life. By exploring my ontological self, I began to demonstrate vulnerability, recognising the assumptions and biases I needed to unpack in outing myself as a person-centred researcher. Moving to the philosophical exploration of the thesis, Chapter 4 moves along the road to consideration of person, personhood and person-centredness. In this chapter, I argue that student experiences in clinical practice are impacted by a lack of understanding of our collective personhood within the nursing profession.

Chapter 5 collectively provides evidence of my investigations of literature that supports this PhD research. Four publications and their contribution to knowledge within this PhD research are discussed. I am the lead author and made a significant contribution to all four publications. The chapter begins with an overview of the exploratory phase of this PhD research, where two initial small research projects were completed to inform the development of the PhD research. Publishing along the way has enabled me to develop skills in writing for peer-reviewed journals and disseminating information developed from this PhD research. The topic of person-centred transformational learning in practice in the context of crafting healthful relationships is emerging within contemporary literature, and the four publications contribute to the person-centred knowledge base for nursing education.

Moving along the journey to Chapter 6, I explore my collage of theorists and persons who have influenced my way of understanding knowledge. I then present a theoretical framework for person-centred learning in clinical practice. This provided a framework for the research and contributes a person-centred perspective to current knowledge about transformational learning in a non-classroom setting. In Chapter 7, I develop and present my methodological principles through the development of a person-centred methodology. The person-centred methodology is underpinned by person-centred research principles and the concept of Dadirri (inner deep listening and quiet still awareness). Each of the elements of the methodology are explored using parts of the

Dadirri poem. Dadirri is an Australian Aboriginal word used to describe listening. Andrews (2019) describes Dadirri as listening more to what you are not saying than what you are saying. Importantly, Dadirri is listening "with your heart as well as your ears" (Andrews 2019, p. 42). The Dadirri poem is shared in full in Chapter 3 (see Image 3-3) for the opportunity to read and reflect on the wisdom shared by Aunty Miriam-Rose Ungunmerr (Ungunmerr 1988).

Chapter 8 presents the methods that were co-created with potential participants and share the research process that was developed to inform the information collection part of the PhD research. Consistent with person-centred research, in this thesis, I refer to information collection rather than data collection. I then move to share the ethical considerations addressed within the research process. Moving along the cobbled road to information collection, in Chapter 9, I share the voice and words of participants and co-researchers as two distinct groups: students; and clinical supervisors. The co-researchers within this PhD research synthesised the information collected at three stages throughout the research process. There are two parts to addressing the research question, aims and objectives. part one considered the definition of healthful relationships in the context of students and clinical supervisor relationships. part two explored how healthful relationships influence person-centred transformational learning. Chapter 10 involves the synthesis and meta-synthesis of the information collected in part one and part two. This is where I use my voice in the third space, my own unique space as a person-centred researcher, to bring together the students and clinical supervisors' voices, creating a shared story of our collective understanding of the research question, aims and objectives. I develop a model for crafting healthful relationships, which is described within this chapter, along with our discoveries about how this influenced person-centred transformational learning in practice. Within Chapter 11, I describe how rigour was applied to this PhD research using the TACT Framework, which is underpinned by reflexivity. Reflexivity is then explained using the concepts of inner space, outer space and how they influence what we seek from the universe throughout the PhD research discoveries. I undertook a reflexive process drawing on my methodological principles to demonstrate a further level of rigour.

Finally, in Chapter 12, I share the key discoveries I made from ontological (personhood), epistemological, methodological and synthesis perspectives. I conclude the thesis with my recommendation and future research directions. My hope is that I have shared the vulnerability, courage, and openness to learn, unlearn and relearn as I have experienced along this PhD journey. I have learnt so much from participants and co-researchers along the road on this journey and I will be forever grateful for their wisdom and trust as they shared their valuable knowledge with me.

Chapter 2

The Background and Context of the PhD Journey

Image 2-1 The Beginning of My PhD Journey - © Maria Mackay 2020

Introduction

I begin the journey in this chapter with a discussion of why this research was undertaken. As identified in the image (see Image 2-1) above, I started at the beginning of the road, a series of steps taken, providing the rationale for undertaking the research. I begin the chapter by discussing the significance of the topic and why I chose to focus on how healthful relationships influence transformational learning in practice. I then move to the use of language that will be used to describe participants and co-researchers in this research. This is an important clarification as person-centred ways of working demand that we consider the language used when referring to or placing a title on others. Finally, I describe the complexity of clinical placements in nursing education and the importance of the student and clinical supervisor relationships in creating positive learning cultures. I conclude the chapter by demonstrating the limited agreement nationally in Australia and internationally on how we describe and understand the facilitation of learning between students and clinical supervisors in the practice context.

How and Why Did I Start this Journey?

The impetus for this journey was my interest in and work with clinical supervisors who supported and assessed students in practice. I had been working as a Senior Lecturer and Director of Clinical Learning (DCL) at the University of Wollongong (UOW) for five years when I started this PhD. In my role, I had the responsibility of education and support for the clinical supervisors. New South Wales (NSW) Health model of student supervision is predominantly that universities employ registered nurses in the role of clinical supervisors to support students during their clinical placement. NSW Health has an unwritten rule enforced by individual health facilities that universities provide one clinical supervisor for every eight students in practice.

Soon after I began working at the UOW, I was overwhelmed with the concerns raised by clinical supervisors about how to provide critical feedback to students whilst they were trying to create a positive relationship and gain their trust. I sought advice from my colleagues on this dilemma. I was fortunate to have the opportunity to have a critical dialogue in 2014 with Professor Jan Dewing, who was then an Honorary Professor with our university whilst she was in Australia undertaking a period of work. After discussing my disorienting dilemma (Mezirow 2000) with her, she generously worked with me to develop learning and teaching resources to facilitate the clinical supervisors' understanding of solution-focused/strengths-based feedback. These concepts developed over time to inform a strength-based way of facilitating learning with students in practice. As a result of the changes we introduced collaboratively, I became aware of the impact of working from a strengths-based perspective on students and clinical supervisors, leading to this focus for a PhD research topic.

The significance of this project lies in the importance of students and clinical supervisors supporting each other to seek their full potential in the reality of the practice context. The practice context can be challenging and unwelcoming for students (O'Mara et al. 2013; Mackay et al. 2014). In my experience as DCL, students commented on the challenges they experienced in practice in relation to the complexity of the context, apparently feeling unprepared for the reality of both caring for persons who are experiencing healthcare and interacting with the multi-disciplinary team.

Although clinical supervisors have a role in helping students to bridge the gap between their theoretical knowledge and clinical competence, they also have their own challenges in creating relationships with students and other nursing staff (Mackay et al. 2014). I always felt passionate that students and clinical supervisors have the opportunity to each learn within the supervisory relationship, enabling each other to be the experts in their educational journey and, therefore, transform their capacity to care as person-centred registered nurses. Thus, this research will focus on crafting healthful relationships between students and clinical supervisors and how this influences transformational learning in practice.

The Use of Language in Describing Students, Clinical Supervisors and Academic Staff

There are three philosophical ideas to draw on when explaining how I refer to persons who are participants and co-researchers in this PhD research. These are personhood, transformational learning theory and power.

Within transformational learning theory literature, there is an academic argument that proposes the term 'learner' encompasses all persons within a learning relationship. Mandell and Herman (2009, p. 78) further argue that the "relationship between the student and the learning facilitator is at the heart of transformational learning". They assert that this relationship is enhanced when the facilitator of learning is aware that their role is not to profess and that students understand they need to be active in their learning.

Language is an important part of this debate and therefore the language that is used in describing students and facilitators of learning contributes to the equality that exists within this relationship. Mandell and Herman (2009) challenge us to consider that persons in these roles may have times when they are the teacher or the learner. Learning can be viewed to be narrow, such as the steps taken to acquire a skill. However, it is argued that transformative learning takes a holistic perspective of learning and describes learning as enabling the learner to transform problematic frames of reference. The learner becomes more inclusive, discriminating, reflective, open and

emotionally able to change (Mezirow 2009). Significantly, in contemplating this, the term student may be one that refers to one person in the relationship, whereas all persons in a learning relationship have the potential to be learners.

In learning relationships, the facilitator of learning is perceived to have power over the student (Mezirow 2000). Within this research, the clinical supervisor holds the formal role as the facilitator of learning as they are responsible for the supervision and assessment of students. This is a perceived power imbalance and can lead to conversations that Habermas (1987) would describe as distorted (Roderick 1986). Arguably this has the potential to lead to a situation where one person (the facilitator or clinical supervisor) holds power over the student. Clinical supervisors have a role to ensure their power is utilised as a positive influence to develop an environment where communication is undistorted (Roderick 1986; Habermas 1987). The undistorted discourse between students and clinical supervisors aims to influence person-centredness, achieve consensus and mutual understanding. Habermas (1987) suggests that through the creation of safe communicative spaces, the environment is created for persons to have an equal voice (Roderick 1986).

Personhood is touched on here and explored in more detail in Chapter 4. McCormack and McCance (2017) describe personhood as living your own life plan true to your own values and beliefs. Personhood is linked to enabling others to be the person they wish to be and to flourish to their own full potential; in this context, this is not imposed or influenced by others' values and beliefs. Because of this, I believe it is important to find out from persons (students or clinical supervisors) about their view and not impose my views on them. I also acknowledge that using a single term within the thesis may not be suitable for all, as it does not acknowledge a person's individuality and may limit them from being able to determine their own personhood. Clinical supervisors employed by the UOW have previously (outside of the research process) participated in the process of determining how to refer to the registered nurses who undertake the role of supervising and assessing students in practice, agreeing that the overarching term to define the different models in place would be clinical supervisors. For the student group, sixty students enrolled in the Bachelor of Nursing at the UOW were

asked if they would prefer to be referred to as a 'student' or a 'learner'. Of the sixty students, fifty-nine wanted to be referred to as students and one person wrote 'I don't care'; no students wanted to be referred to as a learner. The comments that arose from this discussion could be argued to be contextual to this university at the undergraduate level and Australian based. They, as a collective community, believed they had sacrificed a lot to be a student and were proud to be referred to as a student. In a more critical tone, they felt that being referred to as a learner made them feel like they are inferior and a learner driver. This view is in contrast with Mezirow's (1990) argument that the term 'learner' is empowering.

In this research thesis, I use the term learner to describe students and clinical supervisor, seeking to address the potential power differential that may disempower students and providing an equal positioning of both groups participating in the research. This thesis, therefore, uses the following terms to refer to persons who are participants and co-researchers within the research:

- Student – a person enrolled in the UOW Bachelor of Nursing.
- Clinical Supervisor – a person who is employed by the UOW and is responsible for the supervision and assessment of students in clinical practice.
- Academic staff – a person who holds an academic position at UOW or QMU.
- Learner – used to describe students, clinical supervisors and academic staff who are in a learning relationship as a collective.

Overview of the Research Context

This study was based at UOW in Australia. The research took place at multiple sites across UOW as the School of Nursing offers the Bachelor of Nursing (BN) on six campuses. Students and clinical supervisors participated as participants or co-researchers within this PhD research. Students were enrolled at one of the UOW campuses, and clinical supervisors facilitated learning within a NSW Health facility. Information collected is from their experience of engaging in a clinical placement in an associated health care setting in NSW Australia. As this research is participatory in nature, students and clinical supervisors as participants or co-researchers are familiar with navigating across the two cultures of academia and the practice context.

There is a significant variation internationally regarding the number of clinical placement hours that are required for students to undertake as part of their pre-registration degree to be eligible to register as a nurse (Miller and Cooper 2016; Cooper et al. 2020). Miller and Cooper (2016, p.1) reported a wide variation: "Australia requires 800 hours; New Zealand 1,100 to 1,500 hours; UK 2,300 hours; and South Africa 2,800 hours". According to the Registered Nurse Accreditation Standards 2019 (ANMAC 2019), students in Australia must undertake a variety of clinical placements equalling a total of at least 800 hours of practice. I have not been able to identify any reporting of the correlation of hours of clinical practice related to the quality of the graduate nurse. However, Cooper et al. (2020) argue from an Australian perspective that a consistent approach between the university and healthcare provider enables the creation of positive learning cultures in which students can flourish. The UOW offers an accredited three-year BN with approximately 1500 students enrolled across six campuses. Anecdotally, the University has a reputation for providing high quality education to students and producing graduates who are well equipped for practice. Students within the BN may undertake practice across approximately 78 different facilities and services in NSW Australia. UOW has a mandatory 840 hours accredited within its BN. Students undertake a workplace experience (or clinical practice) subject from year one in each academic semester.

Effective supervision is a term used by the accrediting body in Australia, ANMAC (2019), to describe students' support and assessment during a clinical placement. It has been argued that the effective education and support of clinical supervisors will assist them to enable students to integrate the theory they have acquired into the context of practice and to optimise their learning opportunities (Mackay et al. 2014; ANMAC 2019). In support of this, the key training body in NSW, Health Education and Training Institute HETI, argues that effective supervision is "required for the provision of safe and person-centred healthcare" (HETI 2013, p. 11). In considering effective supervision from a person-centred perspective, I will use the phrase 'facilitation of learning' in the thesis to describe the dynamic process of learning between students and clinical supervisors.

There are currently no agreed models for the facilitation of learning between students and clinical supervisors in practice internationally. The United Kingdom countries also have a variety of models, with one being the Hub and Spoke Model, where students follow their mentor/supervisors work pattern (Bradley et al. 2012). Similarly, there is no single agreed model for facilitating the learning of students and clinical supervisors during clinical placements in the Australian context. The most common NSW Health care services model requires education providers to supply an additional resource of one registered nurse per eight students per day. This can be translated as one hour of the clinical supervisors' time per student per day. Currently, at UOW, School of Nursing, there are two models where education providers' resource the supervision and assessment of students to health care services. The first model is where the UOW employs the registered nurses in the role of clinical facilitators. These registered nurses are responsible only for the supervision and assessment of students in practice; they are not involved in providing direct nursing care. The second model is a preceptor model, where UOW remunerates the host health care service at an agreed hourly rate for the supervision and assessment of students, for one hour per student per day. In this model, the registered nurse is employed by the health care service for their primary role as a nurse and undertakes the secondary role of a preceptor, where they oversee the supervision and assessment of students during their clinical placement (Mackay et al. 2014). I believe developing person-centred models and processes that support the facilitation of learning between students and clinical supervisors will provide the scaffold for them to develop skills to provide person-centred care across multiple contexts of practice.

The relationship between students and clinical supervisors in practice has been explored related to the concept of belonging, however, there is a lack of understanding of what the attributes of this relationship are. Within the literature, there are findings related to what constitutes a positive experience and a sense of belonging for students in practice (Courtney- Pratt et al. 2012; Levett-Jones and Lathlean 2007; Levett-Jones and Lathlean 2009; Cooper et al. 2020). However, the literature is silent on models of facilitating learning between students and clinical supervisors from a guideline or 'how to' perspective. Significantly for this PhD research, there is also silence in the area of

person-centred facilitation of learning in the practice context between students and supervisors. Evidence supports that the role of the clinical supervisor is an essential component of the student learning experience and that the relationship between the clinical supervisor and student impacts the student's motivation and sense of belonging (Cooper et al. 2020; Courtney- Pratt et al. 2012, Levett-Jones and Lathlean 2009; Levett-Jones and Lathlean 2007). Once again, there is a pause in the literature as to what this relationship looks like and feels like to the student and clinical supervisor or how a healthful relationship in this context is defined. In the NSW context, clinical supervisors work independently across a wide geographical area, often at a distance to the university. There are concerns raised that the inconsistency of the approach to facilitating learning between students and clinical supervisors in practice contributes to the concerns raised regarding the quality of clinical placements more broadly (Cooper et al. 2020).

Chapter Summary

This chapter concludes with a sense of why this research is required to be undertaken. The literature gaps identified here will be further explored in Chapter 5, where learning from the exploratory phase and two literature reviews are discussed. Much of the current literature raises the enablers and barriers to student learning in practice. Significantly, I have suggested there is a legitimate need to further explore how healthful relationships influence person-centred transformational learning in the practice context.

In the following chapter, the significance of this research being positioned from a person-centred context is explored, along with an exploration of my personal ontology and how that impacts my being in relation to this PhD research.

Chapter 3

Discovering Me and My Ontological Views

Image 3-1 My Ontological Threads - © Maria Mackay 2020

Introduction

The image above (see Image 3-1) is the part of the painting that represents the threads I have explored within this chapter to reveal the personal and professional experiences throughout my life that have influenced how I see the world today. These assumptions include the premise that research is value laden, morally committed and that researchers perceive themselves as being in relation with one and another and situated in a specific social context (McNiff & Whitehead 2011). It is, therefore, critical for me to have considered who I am as a person and my personhood. In this chapter, I have considered the assumptions I hold and have unpacked them to expose my values and beliefs. Significantly, I have then applied a critical theory perspective to explore how understanding my personhood influenced the way I participate in the research and present the thesis.

I begin the chapter by exploring my ontological stance and demonstrating how I clarified the ontological value base for my research work and consider how this relates

to a body of knowledge known as critical theory. To explore my ontological 'I' or my worldview and the influence on the research, I used Kockelman's (2013) ontological stance to examine my own values and beliefs. Reflecting on the influences of my life that impacted the way I see the world, I undertook a journey of self-discovery, which was both confronting and enlightening. At times this felt like confrontation and also exposure, as I began to see me as the person, those parts that are public for others to see every day, and those that I keep hidden. This was enlightening as critical reflection on my assumptions helped me to also realise my true strengths. Mezirow's (2009) model of critical reflection enabled me to reflect on my assumptions and learning perspectives, revealing my core values and beliefs. I conclude the chapter with the unravelling of the threads of my ontological continuum, using Kockelman's (2013) analogy of self (I) to clarify my position within this research.

Background

As this PhD research was participatory in nature, my theoretical stance as the researcher focused on how I held myself accountable and understood the influence of my worldview on the research process and outcomes (McNiff & Whitehead 2011). Dewing et al. (2017, p.20) in their critique of the philosophical perspectives on person-centredness, defines ontology as 'Our view of reality and 'being'. From a participatory research perspective, the ontological "I" is never in isolation, it is always seen within the collective 'we' and the social context of the research (McNiff & Whitehead 2011). Within this PhD research, the collective 'we' form the groups of participants who have the additional role of co-researcher. Decisions were made through constructive discussions by the collective 'we', where I believe we came to a consensus through critical dialogue and mutual consensus (Habermas 1987).

What is my Definition of Ontology?

I began by considering the ontology of critical theory mostly from the perspective of critical realism. Fay (1987, p.42) argued that researchers should consider all ontological paradigms and, if choosing a critical theory based ontological process, did not denigrate other theories but merely provided an alternative for researchers who are interested in the "ontological conception of mankind". Positivism is an empirical

quantitative approach utilised to disprove a hypothesis and to discover facts and relationships that are generalisable to the overall population (Mack 2010). Habermas (1978) considers this to be a traditional ontology in line with positivist thinking; to be of pure knowledge and detached from the participants and context. In considering positivism, I found this did not fit with my research approach as participants will be involved in person-centred research and therefore fundamentally embedded in a participatory paradigm (McCormack et al. 2017).

An interpretivist paradigm is opposite to positivism as it aims to understand rather than to explain, it is not generalisable and is subjective rather than objective (Mack 2010). The interpretivist paradigm does reach into the realms of person-centred research and as such, I will argue here that the critical paradigm reflected my participatory person-centred research approach as it has a transformational emancipatory intent on groups and context. Furthermore, as one of my aims is to explore the impact of person-centred interventions, I focused on the context and the learning culture in clinical practice (Mack 2010). In line with the participatory nature of this research and from a critical theory perspective, the issues of inequality and power are overt and considered by myself, the researcher, within the development of the interventions and reflection on the outcomes (Habermas 1978).

In keeping with the critical paradigm and aligned with the ontological assumptions in person-centred research (McCormack et al. 2017), I recognized that consideration of 'who I am as a person', unpacking my values and beliefs, would enable me to be authentic throughout my participation in and interpretation of this research. In doing so, I followed James' analysis of self as "the sum total of all that one may call one's own" (Kockelman 2013, p. 173). While I considered other definitions, I chose this definition as it resonated with me in the context of person-centred research and my uniqueness and totality as a person. Within this definition, I recognized the different contexts of 'Self'; the self as a wife and mother at home, in contrast to the self when caring as a nurse. I saw the sum total of myself in the perspectives of a daughter, sister, wife, mother, grandmother, friend, nurse and educator. I also realised that how I see the world at any given point is further influenced by my mental sense, this includes the

interactions with others and objects, my beliefs, desires, hopes, and fears (Kockelman 2013). Within this definition, I saw the dynamic nature of my ongoing learning journey where the 'self' and person evolved throughout this PhD journey. I remained open to work with this concept as a continual reflection of me throughout this journey, being inspired by the words of Kockelman (2013) to unravel the parts of my life that have created the sum total of what has influenced me and my worldview:

> … our ontological continuum, which at first looks like a one-dimension line, is really a thread, itself subject to fraying, knotting, and netting, and out of which the cloth of human conduct is stained, stolen and torn as much as woven and worn (Kockelman 2013, p.107).

Through this reflective process explored in this chapter, I came to see myself as a person where my threads were frayed, knotted, netted and woven together; and that the person-centred research process provided the opportunity for the further unravelling of the 'stains' and 'worn patches' (Kockelman 2013).

Self-discovery Methods

In unravelling my own personal ontology, Mezirow's (2009) model of critical reflection provided me with a framework to unpack each thread and to undertake a critical self-reflection of me as a person. Mezirow (1990) argues that to critically reflect, a person must be aware of their assumptions and challenge themselves to consider these assumptions in a way that generates feelings and emotions. He believes it is when challenged that we are enabled to experience transformative learning. Undertaking this critical reflection allowed me to engender deeper meaning in the experiences of my life and has provided a platform for consideration of how this new learning related to my PhD research.

Mezirow (1990) proposed that there are two dimensions of meaning: these are meaning schemes and meaning perspectives. Learning or meaning transformation occurs when a person creates awareness of, and reflects on, their habitual ways of knowing (meaning schemes) and their interpretation of assumptions (meaning perspectives). When I started the doctoral journey, I had not previously experienced my thinking, values or beliefs to be challenged to the point of discomfort. On reflection, I had

accepted the meaning perspectives I held as fact or dogma, rather than assumptions (Kitchenham 2008; Mezirow 2009). Reflection on my fundamental belief systems was challenging and simultaneously generated an emotional response and a level of discomfort. This process created new learning and deeper recognition of how the values and beliefs I hold influenced me as a person and researcher. I will now consider each of the threads in the discussion below.

The Ontological Threads That Have Influenced Who I Am

The image below (see Image 3-2) represents the sum total of me as being the threads within the cloth of my life journey. I have used Kockelman's (2013) definition of the ontological continuum to reflect on the threads within the cloth, along with their knots and frays, thus enabling me to clarify my values and beliefs. The five threads reflect where I saw myself gaining new learning, enabling me to flourish at significant points of my life. Below I provide more detail on these threads and how they represent my professional and personal assumptions and fundamental values and beliefs. As part of my reflection, I share what Kockelman (2013) describes as the soils and stains on the woven cloth, these are the significant events in my life that have influenced my worldview.

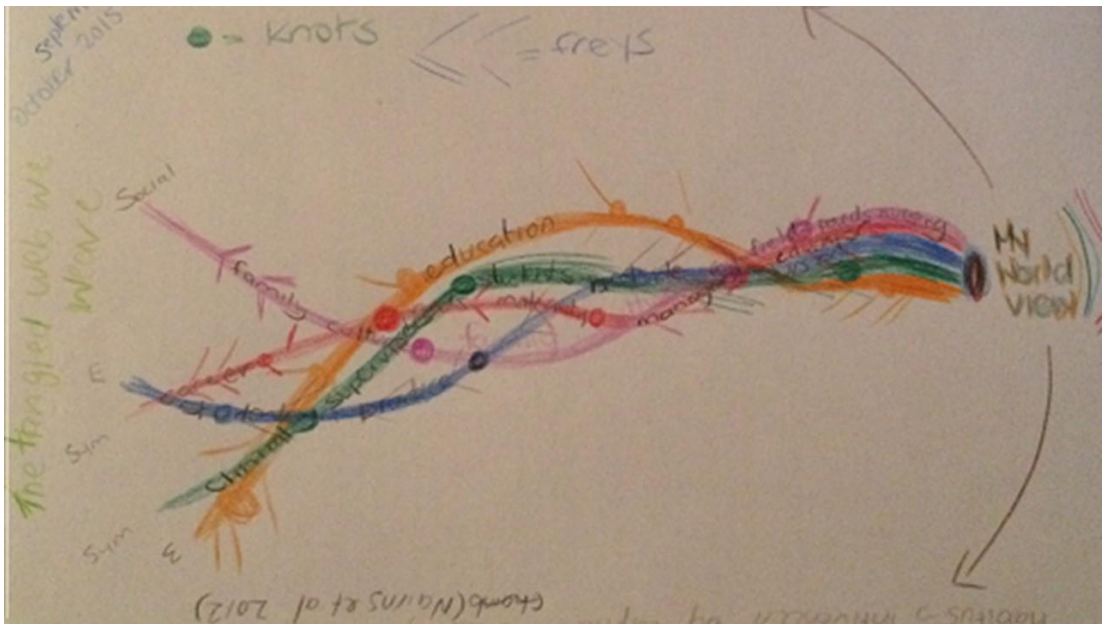

Image 3-2 Ontological Threads (2016)

I next use Mezirow's (2009) 'Model of Critical Reflection' to explore the four significant threads in a chronological order where I can see myself gain new learning perspectives and flourish at significant points throughout my life. The threads allow me to consider the assumptions I hold in different aspects of my personal and professional life and unravel my fundamental values and beliefs.

Thread 1 – How my family and culture have influenced me

My assumptions surrounding my family are firmly linked to my culture. Both my culture and my family influenced the person I am because they have influenced my values and beliefs and my world view. This also contributes to my motivation to undertake this research and continues to shape my worldview. I believe the foundation of my values and beliefs regarding person-centred care came intrinsically from my experiences as a carer in my roles as daughter, sister, wife, mother and grandmother.

Part of my cultural story is that I have Australian Aboriginal heritage. Living in Australia and being from an Aboriginal background, I have found that I was not always accepted in mainstream society. My father was an Aboriginal man who was born in 1928. He was raised at a time when Aboriginal people were counted within the Australian Census as flora and fauna or wildlife, not as people. Children who were believed to be Aboriginal were taken (or stolen) from their families and given to white people to raise, as the current belief at this time was that this would provide them with the best opportunity to succeed in life (Australian Human Rights Commission 2015). There was an emphasis on removing half-caste Aboriginal children from their family as it was thought they would be able to be more easily assimilated into white Australian culture (Australian Human Rights Commission 2015). My father was not taken from his home, but rather, his mother was banished from their home. My Grandfather was a white man, and it was thought my father would have a better life if he were to grow up and be influenced by his white European father rather than his Aboriginal mother.

This opportunity to tell my story is empowering. Storytelling is a long valued Aboriginal custom and one where I learned to connect with my family and the broader community in sharing how I see the world. I am an Australian Aboriginal woman. I

never met my grandmother and I know very little of my culture, my genealogy and my ancestry. I do feel that my loss of culture and identity has impacted on me as a person and how I see the world. I have always felt that I did not fit with the 'norm' or mainstream. It was when I related this 'sense of difference' to my culture and 'loss of belonging' to my land that I began to make sense of these feelings and found peace in gaining this understanding.

I have experienced life as a daughter, a sister, a wife, a mother and a grandmother. These are the knots and frays that have most influenced how I see the world. The most significant part for me has been in my life as a wife, mother and grandmother. This has challenged me and how I care for others, putting others needs before my own. I am ever in wonder of the power of love and how this affects our ability to care for others. I see the influence that my relationships with others have enabled me to develop an embodied knowing of love and caring. I see the relationship of this thread to my PhD research in the assumption that caring is an essential part of humanity. I bring this value of caring into my professional life as a nurse and my connection with person-centredness (McCormack and McCance 2017).

In summary, I believe that:

- a person's experience of family and culture influences each of us as a person in our personal and professional way of being
- Caring is an art and is innate within me and others, contributing to the teachable moments to be learned and developed over time.

Thread 2 - How working in nursing has impacted on the way I see the world

I have been very fortunate in having a long and varied career in nursing and midwifery. I have held many positions in a variety of clinical and management roles in the public health system in Australia. Experiences throughout my career have played a role in shaping my world view, how I value nursing and the assumptions I hold regarding the profession. I undertook my nurse training (pre-tertiary education in Australia for nurses) in a paediatric hospital and have worked with children for the majority of my

clinical career. In Australia, we have a comprehensive approach to nursing registration where we are registered to work within specialities of nursing, with the only separate registration, that of midwifery. In summary, I brought to the research a view of clinical nursing through the lens of a paediatric nurse.

I believe that persons (children and their families) should be involved in decisions regarding their care. As part of my initial nurse education course, I spent six months at an adult hospital. During that time, I could not understand why the individual in the bed was cared for in exclusion of their family and significant others. While exploring the theory of family centred care and solution-focused nursing, I have been able to make sense of how I see the world of nursing (McAllister 2007; Smith and Coleman 2009; Walsh 2010). I, therefore believe, nurses need to have the ability to enable people in our care to be active in decision making and experts in their own care (McAllister 2007; Walsh 2010).

My interest in person-centred care developed during my nursing career and was further influenced by frequent comments from parents of children whom I have cared for, who stated that I am a very caring person. I have never been sure why I would be viewed differently from other nurses. While working at a hospital in Sydney, NSW, I provided ordinary care that was viewed as extraordinary. As an example, after providing what I perceived to be ordinary care to a child, I was approached by the mother of another child who had been in the hospital for the past nine months. She talked to me about how she observed how caring I was as a nurse. She stated that she had not experienced other nurses caring in the way that I was caring for children. I was left feeling sad, as the profession, I proudly belonged to was not perceived by this mother to be caring. I do believe nurses are caring people and that there are moments in their care when they are person-centred. For many reasons, including personal and organisational (McCormack, et al. 2011), compassion may not be evident. Fundamentally, I believe that if nursing values the art of authentic caring, we will be able to move from moments of person-centred care to a culture of person-centred care.

I felt that my values and beliefs related to the nursing profession grew as the research evolved. I believe that I gained much from the process, my participants and co-researchers within the research. I embraced the challenges and rewards that were presented to me. This PhD journey helped me develop further as a person-centred researcher and in my understanding of the principles of person-centredness and advance my learning perspective regarding the application of person-centred ways of working. I believe a person-centred researcher is a person who is connected to the research, open to participate authentically with others and able to allow the research process to determine the outcomes achieved.

In summary, I believe that:

- I experience the world of nursing through the lens of a paediatric nurse

At this point, my values are:

- registered nurses need to have the ability to enable people in our care to be active in decision making and experts in their care
- if nursing values the art of caring more authentically, we will be able to move from moments of person-centred care to a culture of person-centred care

Thread 3 – The historical influence of nursing education on the culture of nursing

I believe the history of nursing education in Australia influences how nurses today view students in practice in Australia. Historically, nursing programs were conducted through individual hospitals, with the elements of each program differing from each other. The focus was on teaching nurses what to do in the context of the needs of that hospital (Clare et al. 1996). I undertook my initial nursing programme within the hospital-based system, and although I enjoyed my training, I envy the opportunities that students have today. Hospital-based nursing programs have now been entirely replaced by university preparation for entry into the nursing profession as a registered nurse in Australia since 1985 (ANMAC 2019). This change has enabled nursing to be recognised as a profession; however, it remains an emerging profession regarding academic research and identity with other health professionals in Australia and internationally.

While undertaking the doctoral study, I continued for some of the time as DCL at the UOW, NSW Australia, travelled across health care facilities, often hearing negative comments from both hospital and university educated nurses about student nurses. This included denigration of current pre-registration training as inferior to the previous educational experiences of registered nurses. These comments and emotive judgments left me feeling frustrated and unsure of how to respond. I experienced this as a disorienting dilemma (Mezirow 2000), albeit anecdotal, where nurses in practice appeared to believe that university programs did not now adequately prepare students for practice.

In Australia, nursing graduates are eligible for comprehensive registration after a three-year (or equivalent) degree. Whilst these nurses are eligible to be registered within the nursing profession to work as nurses, Barton et al. (2009) argue it is not realistic to expect that a student can be prepared to work across the breadth of the nursing profession following this education period. I agree with this and believe that the nursing profession, therefore, holds expectations that are incongruent with what the university sector is expected to meet. Graduates are well prepared as novice practitioners; however, they do require support and further training to gain experience and expertise in their chosen speciality area of practice (Barton et al. 2009). I believe that the pressure experienced by nurses in the clinical environment consequently influences their expectations of recent graduate nurses to hold the skills and expertise of an experienced registered nurse.

In summary, I believe that:

- it is a challenge for the nursing profession to consider how we bridge the gap between university education and clinical practice for students

At this point, my values are that:

- the skills and attributes that university qualified nurses bring to the profession are valuable
- that registered nurses have the influence to enable the development of high-quality nursing practice

- that person-centred care at the point of care is achieved when nurses themselves feel cared for and valued

Thread 4 - My journey from clinician to an educator

I entered the world of academia after many years working in the public health system and at the time I left the health service I was working in a senior manager role. I felt I had something to offer learners; experiences to share. I quickly learned that enabling others to learn had little to do with what I knew and that it was more about what the student had to offer. It was then that I recognised the student as an expert in their learning journey. In a sense, this was a transformation in my development as a facilitator of learning.

This transformation occurred after I read Freire's' (1996) work on "Pedagogy of the Oppressed" and my perspective changed. I realised my language was very much about telling and providing information. My initial thought was that students wanted to be provided with information. It was from my reading of Freire (1996) that I realised that as a facilitator of learning I would value the student as the expert in their educational journey. Later, I was introduced to Practice Development and worked with students and registered nurses in creative ways to unlock their expertise, enabling them to create new learning (McCormack et al. 2013; Dewing et al. 2014). Learning to use practice development approaches also enabled me to personally and professionally grow and to facilitate others in their learning journey. This enabled the shift in my worldview as an educator to view the learner as an expert. I have enjoyed coming to understand that challenging learners to think creatively challenges them to consider their role in creating person-centred learning cultures.

From a more personal perspective, unpacking my thoughts and feelings about authenticity related to person-centred learning emerged as something that I needed to consider moving forward. Brene Brown (2012) argues that we are not different persons when we are undertaking the many roles we hold in our daily lives rather, we are one person who holds the same values and beliefs, and these may look slightly different but remain fundamentally the same. She further argues that authenticity is a daily

practice (Brown 2012). The person-centred practice framework (2017) considers authentic consciousness to be when we can practice within others' values and beliefs. Therefore, in this process of clarification of my ontological threads, I hope that by exploring the student and clinical supervisor relationship, we can engender a feeling of knowing self and how this can enable students to be in practice authentically (McCormack and McCance 2017). Authenticity needs to be considered in context to create and maintain safe spaces. I would argue that the nursing profession is beginning to consider self however, this is in its infancy. Students going into practice need to be prepared for the reality of the practice context, where they may be seen as different if they embrace values-based ways of being as a nurse.

It was therefore, an obvious step for me to recognize the importance of students and clinical supervisors as both participants and co-researchers in the PhD research, valuing their expertise in all stages of the research process. This was consistent with my belief that each person brings all they need to contribute to the research; my role is to help them realise and unlock this knowledge. I believe that when we interact with others, we need to respect their expertise and value the contribution they make.

In summary, at this point my values are that:

- creativity helps to unlock hidden knowledge, creating a unique learning space
- when we interact with others, we need to respect learners are experts in their own educational journey

Dadirri

Drawing on my Aboriginality and ways of seeing the world ontologically, the concept of Dadirri (inner deep listening and quiet still awareness) is something that has become a significant influence on me personally and as a person-centred researcher. I have included the poem below (see Image 3-3) with permission from the Miriam Rose Foundation (April 2020) (see Appendix A). They asked for the following to be included within this thesis to acknowledge Dadirri appropriately using the following words: *"Dadirri is a word from the Ngangikurungkurr Language. Miriam Rose is an Elder from the Nauiyu Community, Daly River, Northern Territory."*

The version of Dadirri on the Website for the Miriam Rose Foundation is the original 1988 version of the poem (https://www.miriamrosefoundation.org.au/about-dadirri). This version was edited and previously available online and is included in this thesis however, the link is no longer available. The edited version is the words of Aunty Miriam Rose Ungunmerr and has been edited by Judy Atkinson who uses the words from Aunty Miriam Rose within her trauma informed research, no date is provided (http://leadpda.org.au/documents/leadpda_rap_dadirri.pdff). I will use the reference to Dadirri as Ungunmerr 1988 as this was the original resource I accessed before the edited version and the words from the edited version are within the text (see Image 3-3).

I have read this poem many times and each time, it speaks differently to me. The words of this poem have been threaded throughout this thesis with an explanation of their meaning and relevance at points along my PhD journey. Dadirri becomes more prominent in this thesis from Chapter 7 onward however, it has influenced the whole thesis as a method of contemplation (Ungunmerr 1988).

Dadirri

Listening to one another (The Aboriginal Way)

Inner deep listening and quiet still awareness.

Edited version adapted from the writings of Miriam-Rose Ungunmerr.

Dadirri. A special quality, a unique gift of the Aboriginal people, is inner deep listening and quiet still awareness. *Dadirri* recognises the deep spring that is inside us. It is something like what you call contemplation.

The contemplative way of *Dadirri* spreads over our whole life. It renews us and brings us peace. It makes us feel whole again. In our Aboriginal way we learnt to listen from our earliest times. We could not live good and useful lives unless we listened.

We are not threatened by silence. We are completely at home in it. Our Aboriginal way has taught us to be still and wait. We do not try to hurry things up. We let them follow their natural course – like the seasons.

We watch the moon in each of its phases. We wait for the rain to fill our rivers and water the thirsty earth. When twilight comes we prepare for the night. At dawn we rise with the sun. We watch the bush foods and wait for them to open before we gather them.

We wait for our young people as they grow, stage by stage, through their initiation ceremonies. When a relation dies we wait for long time with the sorrow. We own our grief and allow it to heal slowly. We wait for the right time for our ceremonies and meetings. The right people must be present. Careful preparations must be made. We don't mind waiting because we want things to be done with care. Sometimes many hours will be spent on painting the body before an important ceremony.

We don't worry. We know that in time and in the spirit of Dadirri (that deep listening and quiet stillness) the way will be made clear.

We are like the tree standing in the middle of a bushfire sweeping through the timber. The leaves are scorched and the tough bark is scarred and burnt, but inside the tree the sap is still flowing and under the ground the roots are still strong. Like that tree we have endured the flames and we still have the power to be re-born.

Our people are used to the struggle and the long waiting. We still wait for the white people to understand us better. We ourselves have spent many years learning about the white man's ways; we have learnt to speak the white man's language; we have listened to what he had to say. This learning and listening should go both ways. We would like people in Australia to take time and listen to us. We are hoping people will come closer. We keep on longing for the things that we have always hoped for, respect and understanding.

We know that our white brothers and sisters carry their own particular burdens. We believe that if they let us come to them – if they open up their minds and hearts to us. We may lighten their burdens. There is a struggle for us, but we have not lost our spirit of Dadirri.

There are deep springs within each of us. Within this deep spring, which is the very spirit, is a sound. The sound of Deep calling to Deep. The time of re-birth is now. If our culture is alive and strong and respected it will grow. It will not die and our spirit will not die. I believe the spirit of Dadirri that we have to offer will blossom and grow, not just within ourselves, but in our whole nation.

Experiencing Dadirri

Clear a little space as often as you can, to simply sit and look at and listen to the earth and environment that surrounds you. Focus on something specific, such as a blade of grass, a clump of soil, cracked earth, a flower, bush or leaf, a cloud in the sky or a body of water (sea, river, lake) whatever you can see. Or just let something find you be it a leaf, the feel of the breeze, the light on a tree trunk. No need to try. Just wait a while and let something find you. Lie on the earth, the grass, some place. Get to know that little place and let it get to know you- your warmth, feel your pulse, hear your heart beat, know your breathing. Just relax and be there, enjoying the time together. Simply be aware of your focus, allowing yourself to be still and silent..., to listen. Following this quiet time there may be, on occasion, value in giving expression in some way to the experience of this quiet, still listening. You may wish to talk about the experience or journal. This needs to be held in balance - the key to Dadirri is in simply being, rather than in outcomes and activity.

In greeting each morning, remind yourself of Dadirri by blessing yourself with the following..."Let tiny drops of stillness fall gently through my day "*Noel Davis*

Image 3-3 Dadirri Poem (Ungunmerr 1988)

Chapter Summary

To begin the summary of my personhood, I have written a Haiku poem which has enabled me to creatively represent my world view and subsequently has influenced this PhD research.

Poem
Exploring myself
Ontology how I see
What I value and believe

Practice enables
Caring for our profession
Challenge the process

Hope for authentic
Question our moral courage
Person-centred care

This Haiku poem above represents who I am in my personhood, who I wish to be when I am authentic to my values and beliefs and who I strive to be each day. Being authentic to our values and beliefs is an ongoing challenge for each of us and one that takes courage and commitment to achieve. It is a mindful process as the ethical challenges we face each day create the choice for us to have the courage to stand up for what is right or to sit with the 'norm' and not challenge the process.

In the above reflections, I have challenged my meaning schemas or habits of knowing and explored the perspectives or assumptions I hold to create new learning (Mezirow 1990). The threads of my ontology (see Image 3-2) are interwoven and represent my life experiences just as the knots and frays have influenced the assumptions I hold and the way I view the world, both personally and professionally. The worldview I hold at any given time can transform and integrate through my life experiences and enable me to gain new learning perspectives (Mezirow 1990). Self was defined as "the sum total

of all that one may call one's own" (Kockelman 2013, p. 173); this in a cultural sense can be individual as well the self can be communal (as in groups and professions). Exploring self as the sum of who I am has had a profound impact on my ability to consider self and my actions and behaviours and this is further explored as a key discovery in the final Chapter 12, where I am able to contemplate the change to the sum of me as a result of undertaking this PhD research journey.

In my current self (I) (Kockelman 2013), I hold values and beliefs that create the worldview I took with me into this research. This includes:
I believe:

- I experience the world of nursing through the lens of a paediatric nurse
- a person's experience of family and culture influences each of us in our personal and professional way of being
- Caring is an art and is innate within me and others, and contributes to the teachable moments to be learned and developed over time
- it is a challenge for the nursing profession to consider how we bridge the gap between university education and clinical practice for student

At this point, I value that:

- registered nurses need to have the ability to enable people in our care to be active in decision making and experts in their care
- registered nurses have the influence to enable the development of high-quality nursing practice
- the skills and attributes that university educated nurses bring to the profession are valuable
- creativity helps to unlock hidden knowledge and this creates a unique learning space
- when we interact with others, we need to respect learners are experts in their own educational journey
- person-centred care at the point of care is achieved when nurses themselves feel cared for and valued

In the feedback I have received from a peer, it is stated that I "see inspiring and encouraging others as part of my own journey" and that "… (my) sense of responsibility overrides (my) own goals." These statements both please me and challenge me as I can see they are what drove my interest in this PhD research however, it is also what took my time from my studies and was a distraction for me along the way. Within the uniqueness of me as a person, my peer also stated that I "respect the uniqueness of people in a broad sense" and "value the learning that uniqueness brings". The uniqueness of self is an interesting thing to contemplate and one that I believe fits well with this PhD research, where I value the uniqueness of each of the co-researchers and participants and allow them to shine in their own unique way in this thesis.

In the following Chapter 4, I will show how my world view fits with my philosophical understanding of person, personhood and person-centredness. This chapter also relates to Chapter 4, where I explore my theoretical perspectives and how they influence how I understand the world. For me, it is important that my world view is congruent with that of the philosophical understanding of personhood and the theoretical underpinnings, as this will form the basis of how I make sense of the research topic and question.

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Chapter 4

Moving along the Road to a Philosophical Exploration of Person, Personhood and Person-centredness.

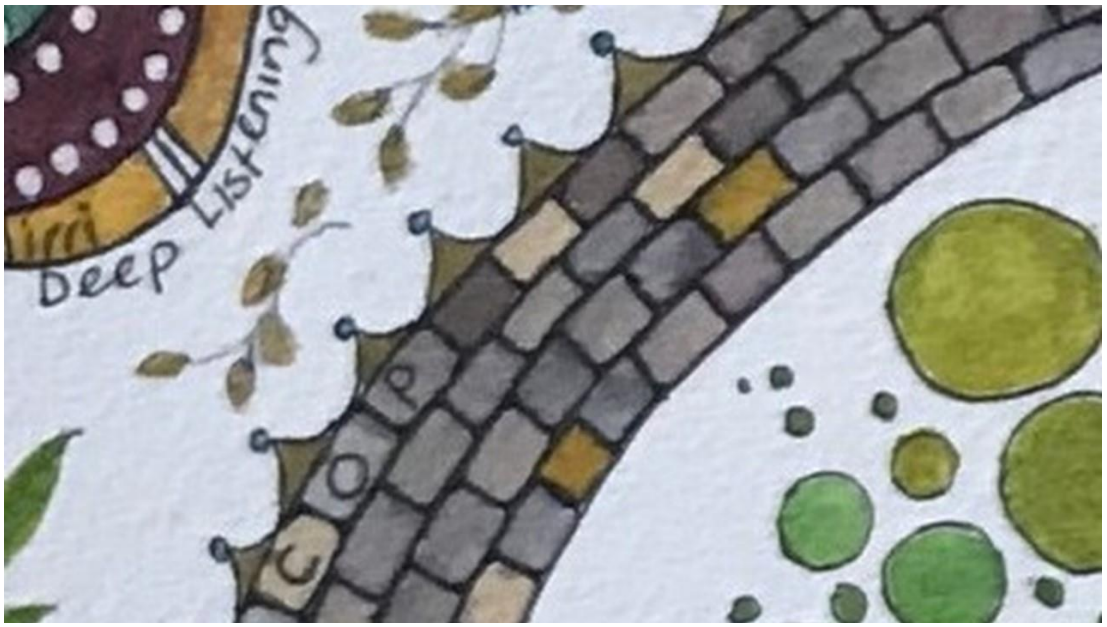


Image 4-1 Moving Along the Road to Person, Personhood and Person-centredness - © Maria Mackay 2020

Introduction

In this Chapter, I move along the road as shown in the image above (see Image 4-1), from the consideration of self to one of what is a person, personhood and person-centredness. I begin by exploring what the term person means from a philosophical perspective. In this part of the chapter, I critically engaged with what it means to be a person and what it means to be a human being. I conclude by stating that I believe a person is a complex being who has a moral conscious that is connected to our mind and body. I do not believe that other beings such as animals and robots are persons, however, I respect that this may not be the opinion of others. I accept my personal ontology has impacted how I see the concept of person, personhood and person-centredness. In exploring personhood, I considered various philosophical approaches to the concept, concluding that as persons we have the right to determine our own personhood. Deconstructing person-centredness, I argue that this is a way of being that requires persons to act in a way that is true to their espoused values and beliefs. I

conclude the chapter by using the concept of collective personhood to illustrate the limited collective understanding of personhood within the nursing profession. My belief is that this represents a poor understanding of nursing personhood, which impacts how students are treated as persons in the practice context.

Person

The term ‘person’ is complex in its own definition, as the duality of the term in the concepts of person and humanness leads to challenges in describing and defining the holistic concept of a person. Scruton (2017, p.30) describes the complexity of defining the term ‘person’ “not as a biological problem but a philosophical one that is founded in the issue of “the relation between a human animal and the person” This is further examined by Torchia (2008, p. xi) who argues that there is a “technical or mechanical representation of person,” although this view of person as non-human was not something I previously considered. While acknowledging that we hold a moral obligation to recognise all species' rights, including animal, I do not view non-humans as persons.

I also do not agree that a robot or other objects, regardless of their programming, are persons. Where a robot or animal may provide companionship to a human, the key difference is in a human person's relational ability to care. For example, I argue that a person’s experience of family and culture influences their personal and professional way of being. The art of caring is both innate to us as persons and a skill that can be learned and developed over time. Conceptually, the human person may therefore be viewed in the context of what people ‘do’ as opposed to what people ‘are’ (Smith 2010). I argue that in this fundamental art of ‘doing’, we create the person. In a sense, there are two positions: the person as a void receptacle that our society creates; and/or the person born with inherent attributes that create much of who we are. Philosophers dating back to Socrates have argued for the duality of a person; the human being with both a soul and a body (Torchia 2008). I would argue for a more integrated view of body and soul. Soul, in this context, is our moral consciousness within our mind and thoughts, with mind connected to our body and influencing our embodied actions.

Examining the history of philosophy concerning personhood, Torchia (2008, p.1) in his book draws on Trigg's viewpoint of competing anthropological perspectives that have two competing viewpoints: one teleological and the other mechanistic. In the teleological perspective, there is an emphasis on the metaphysical distinction between the 'immaterial mind' and the 'material body'. At the same time, the mechanistic perspective focuses on 'mental capacity' and 'decision making' as complex neurophysiological processes. Aristotle as a student of Plato's, argued for a Western intellectual and humanistic perspective and challenged Plato's viewpoint of the duality of body and soul, contending there is actually a unity of body and soul. Singer (1979) critiqued the views of Aristotle, debating the issue of rationality and hierarchy in animal species including humans and countering this with an opposing view that we are all equal in the animal kingdom. The concept of equality is interesting; equality in this sense I believe supports my worldview that animals deserve to be respected for their uniqueness, without a need to define all as a person. Where Singer (1979) argued for our personhood as providing superiority over animals, I contend that by respecting individual uniqueness of human and animal, we are in fact achieving more equality in our co-existence.

Torchia (2008) argues that Christian writings by Aquinas and Augustine emphasised the individuality and relational being of persons. Augustine considered that while animals exhibit social behaviours, humans have the capacity to love in a selfless way and are therefore unique as persons (Torchia 2008). This quality of selfless love is one that humanity may aspire to, however, I would argue that this is not an attribute in all humans. Aquinas considered that the body and soul are conjoined in a unified reality (Torchia 2008). He further argued that humans bear the reality of God's Trinity of the 'Father, Son and Holy Ghost' in their intellect, although this may not be true reality (Torchia 2008). Sin and Christianity validate the killing of animals and suffering, with an argument that this is reasonable if providing for the good of humans (Torchia 2008). However, Singer (1979) challenged the belief that God has subjected all things to man, arguing that it matters how we treat animals as they have moral status.

A further perspective on the human person as being different from objects and other animals is that humans can question and change our ways of being through education. Scruton (2017) suggests that we need to continue to ask questions however, as humans, we need to do this gently and ensure we listen for the answers. This suggests that as persons, we have a moral conscious that helps us to create the societies in which we live in, guiding our ability to self-reflect and develop our understanding of our world. This viewpoint has been critiqued by many, including Singer (1979), who argued that human beings have no greater status or moral rights than any other animals. In essence, where I respect other animal species' uniqueness and objects such as robots, I do not recognize these as persons. Indeed, to identify them as such would in fact be disrespectful to their unique individuality. Bestowing the status of person to all animals and objects in itself assumes a superiority. Where I, therefore, acknowledge the various debates around what constitutes a person, I believe that debating these different worldviews provides a context in which we can respect our differences.

Contemporary literature also continues the debates around person. McCormack and McCance (2017, pp. 13-14) challenged us to consider if "animals have the ethical and moral rights of a person". As shown earlier, Aristotle's belief in animals and humans as unequal assumes inequality of rights (Torchia 2008). This philosophical stance is challenged by recent writers such as Scruton (2017), who argued that some animals or species have greater rights than humans, due to the similarities in animal and human behaviours. However, Scruton suggests that it is the Kantian perspective of self or 'I' that discerns us from other animal species that humans' sense of self-conscious reflection is evidence of our differences from species such as chimpanzees. Scruton (2017) suggests that although we share similarities in territorial protection, it is the self-sacrifice that humans possess that differentiates us as a human species.

The concept of attributes is an interesting issue as each attribute that is suggested can be argued against with a counter argument. If a person displays narcissistic behaviours and has limited ability for self-sacrifice, are they less a person and does this impact their humanness? Singer (1979) offers a view that non-humans or animals have attributes and rights. We as humans need to consider the ethical issues with devaluing

animals to ensure that we treat them as lesser creatures and utilise them for food. Interestingly, he does not extend this to robots or objects.

In considering the term person, I do believe in a unified body and soul and that, although our social interactions largely shape us, we are, as humans born with innate behaviours. To the question of is there a soul? I believe as humans, our minds and thoughts create our moral way of being, and this can be considered our soul. In essence, I argue that our moral thoughts are influenced innately within and also by our experience of the social world.

My view is formed from my experience as an individual human, an Aboriginal woman, and a wife and mother. The concept of person in Aboriginal culture does not have a strong individual meaning rather a person is a member of a community. In Australia, the concept of person is challenging for me as Australian Aboriginal and Torres Strait Islander people were not considered a person within the Constitution in Australia until 1967. If I was registered as an Aboriginal female baby when I was born, I would have been registered as fauna and flora, not a person (Commonwealth of Australia 2013; Australian Human Rights Commission 2015). I have a memory as a young child that I consciously wanted to create a different life than the one I was born into; this was an internal drive that contrasted with the social environment I was raised in. Fundamentally, I believe in unity of body and soul as I embody my values and beliefs and it is from my life experience that I form who I am as a person.

I am also a mother of three children, all of whom socially have had similar influences however, as individuals, they are very different people. I believe one of the most challenging aspects of parenthood is to allow your child to be the person they want to be. My concept of person has also informed my view of personhood and this research in that I also believe that enabling students to become the registered nurses they want to be, not the one I hope for them to be is also a challenge for myself and for most academic staff I know.

In summary, a person is a complex human being who has both a moral consciousness and mind and a body. I believe what we do as a person is influenced by our moral consciousness and is innate within us and influenced by the social context we experience. I believe that our body and soul are not separate; rather, I believe in unity as I believe what we do influences who we are as a person.

Personhood

Personhood is a term used to describe the fundamental attributes of a person (Dewing 2006). Alzheimer Europe (2017) defines personhood in five aspects or dimensions: inherent/transcendental personhood; capacity-based approach to personhood; interpersonal theories of personhood; the body; and empirical research into the perceptions of personhood.

In the inherent/transcendental perception of personhood, Kitwood (1997) has an influential voice in this perception of personhood with much of his work being undertaken in the area of dementia. Kitwood (1997, p. 8) defined personhood as "a standing or status that is bestowed upon one human being, by others, it implies recognition, respect and trust." There is an argument that personhood is linked to a sense of well-being and it is unreasonable to assume that any person, including those with dementia is always in a state of well-being (Mitchell and Agnelli 2015). This theory has further defined a set of behaviours that do not support a person's well-being, referred to as malignant social psychology. The underlying premise in malignant social psychology is that all people have the want and ability to demonstrate love and kindness in their care of people with dementia. Kitwood (1997) argued that the inability to care was related to education rather than the personhood of the carers. I would argue this is a limitation to Kitwood's definition as there is an underlying assumption that loving and kindness are innate in the more educated within society and lacking in others. I would argue that it is more about the person than their education.

The capacity-based approach views personhood in the context of attributes that a person possesses. In this context, when a person is born without attributes or capacity or loses capacity during their lifetime, a possible question arises: are they less a person (McCormack and McCance 2017). Personally, I find it useful to draw on the Kantian perspective person based on a recognition of the capacity of rationality and logic (Scruton 2017). This perspective of personhood also raises a challenge as to whether society values a person as non-human if they cannot communicate and risks disregarding their value within society (Mitchell and Agnelli 2015). Clearly, the view of personhood in relation to a person's attributes can be subjected to different constructions based on various categories and hierarchies, with varied inclusion and exclusion criteria (Dewing 2019).

Personhood from an interpersonal theory perspective considers that social interactions or relationships create one's sense of personhood. There are several definitions of personhood that support this definition including: who one is and who one can be are defined in the context of authentic relationships (Malloy and Hadjistavropoulos 2004, p. 152); and "a dynamic concept, refined and articulated through constructs and subsequent social intercourse" (Jenkins and Price 1996, p. 64). Additionally, Kitwood (1997) proposed a relational definition of personhood. This places a significant judgement on those who are not able to connect at a relationship level with others for a variety of reasons and ignores the possibility of personhood as a relationship with self (Sabat 2001). McCormack and McCance (2017) argue that developing relationships that respect another's personhood builds on the strengths of persons.

The concept of personhood and the body relates to the inner feelings we have that guide us as a person. The concept of the body relates to the historical concepts of a person's body and soul, both from an aspect of duality and unity (Torchia 2008). Merleau-Ponty (1989) argued in favour of unity suggesting that embodied knowing emphasises the importance of knowing through the movements in our body. This reflects earlier definitions of person, and an emphasis on a unified body and soul where mindful thoughts and ways of knowing influence our physical body in the form of actions. This unity of body and soul is arguably deeper than a relational form of being within the world (Scruton 2017).

Empirical research suggests that a person maintains their personhood or their personal awareness and individual uniqueness until death (Mills and Coleman 1994; Downs 1997; Kitwood 1997). Similarly, Scruton (2017) argued that personhood is a human duty and considers this from a human nature perspective in the I-YOU relationship, where we hold each other accountable for what we are, what we feel, what we think and what we intend. McCormack and McCance (2017, p.16) proposed that personhood is enabling a person to live their life plan without placing our values and beliefs upon them. McCormack and McCance (2010, p. 16) argued that if personhood is viewed as authenticity, it "starts from the position that everyone has 'inborn potential' but that individuals learn how to exercise this potential through socialisation." They further consider persons' life plan as being represented in how they chose to live their life. I have become aware of this in reflection on my own practice. Regardless of the situation, I believe that people have inborn potential. I have however, become aware that both myself and others do not always enable students to live their own life plan without placing our values and beliefs upon them.

How I define a person influences how I understand the concept of personhood. From an Aboriginal perspective, it is important to clarify the similarity between personhood and identity. The Aboriginal concept of personhood is described as identity. It is Aboriginal people who decide on their identity, not others. The focus on identity for Aboriginal people comes from having no identity or personhood following the colonisation of Australia without a Treaty. This act took away the rights of Aboriginal people and in fact, placed them in a position of slavery (Australian Human Rights Commission 2015). Human agency is defined as a person's thoughts and beliefs to express one's individual power (Scruton 2017). Having no rights, which is taking away the right to vote, being part of society, and keeping their children, provided Aboriginal people with no sense of agency.

In summary, personhood to me is determined by the person, not by others and it is living your own life plan, true to your own values and beliefs. Personhood is linked to enabling others to be the person they wish to be and to flourish to their own full potential, without this being imposed upon or influenced by others' values and beliefs.

I believe that placing values and beliefs on others is something that society and particularly the nursing profession need to become more aware of and challenge ourselves to see if we truly start from a position that people have inborn potential.

Person-centredness

Person centredness is a feature of many frameworks and models in nursing. In this thesis, I focus specifically on the Person-centred Practice Framework as developed by McCormack and McCance (2017). In the re-presented framework, McCormack and McCance (2017, pp. 37-38) revised the definition of person-centredness following an analysis of stories told by persons experiencing care. They argue that the messages within these stories do not reflect poor technical competence of staff, rather they express concern about the experiences of persons receiving care within the context of health care as dehumanised. The definition of person-centredness is an ongoing process of developing within the context of current research and has been broadened to consider humanising healthcare by McCormack and McCance (2017, p. 3) as:

> … an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by the values of respect for persons, individual rights to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development.

Healthful relationships in this context are evident when decision making is shared, staff relationships are collaborative, leadership is transformative and innovative practices are supported. They are attributed as the ultimate outcome in developing healthful cultures that are person-centred (McCormack and McCance 2017, p.60).

Similar to my position, as set out earlier in the chapter, McCormack and McCance (2010, p. 16) argued that if personhood is viewed as authenticity, it "starts from the position that everyone has 'inborn potential' but that individuals learn how to exercise this potential through socialisation". They further considered a person's life plan as being represented in how they chose to live their life (McCormack and McCance 2017). Respecting an individual's autonomy is a key consideration in person-centred nursing. I would argue that nurses have a role in enabling a person to realise their life

plan or to exercise their autonomy. The privilege of ensuring authenticity in decision making in line with the person's way of being in the world is a profound responsibility in the nursing profession and one that nurses should be mindful of in the provision of person-centred care. To ensure we maximise the person's autonomy, nurses need to consider the person's way of being and not allow their own values and beliefs to blur their actions (McCormack and McCance 2010; McCormack and McCance 2017).

Person-centredness as a concept in caring is complex and one that is not well understood in the NSW Health context, where this PhD research was undertaken. McCormack et al. (2011) argued that person-centredness needs to consider moving from 'moments' of person-centredness to a more consistent culture of 'person-centredness. Thus person-centredness is a culture rather than a set of tasks. The Compliance Service Improvement and Innovation Model (CoSII) (Dewing and McCormack 2017) is a model that considers the person-centred culture within organisations. Consideration of vitality on one axis versus time and absorption of knowledge including innovation on the other axis informs the consequences of person-centredness within a culture. In organisations where there is a compliance or performance culture, moments of person-centredness are evident. Building on these ideas, where there is service improvement or thriving culture evidence of more connectedness in the moments of person-centredness will expose person-centred patterns. Finally, in a culture that could be argued to be utopian, innovations and flourishing will be evident in a true culture of person-centredness, throughout all aspects of the organisation (Dewing and McCormack 2017).

In summary, I believe person-centredness is a way of being that is true to my values and beliefs and my interactions with all people in the health care environment. This enables me to live my values during my interactions with others, to be authentic and to live person-centredness; however, I am not always successful. I have become mindful of reflecting on the times I do not achieve this and consider how I can improve on my reactions to others. An example would be, when I interact with my colleagues, I may get along with some more than others and I need to be mindful that I am kind and fair in my responses and behaviours. My own experiences suggest that we need to

understand ourselves and consider how we impact the culture in which we work, rather than contributing to a culture of blame within our workplaces. In essence, focusing on the ordinary or simple things we do, can have an extraordinary impact on our ability to influence person-centred care. I believe nurses have a role in influencing person-centred cultures and raising awareness amongst the healthcare team on the importance of connecting moments of person-centred care to enable the movement towards patterns of person-centredness. In terms of this thesis, work with students should not devalue the student and deflate their inborn potential. There are many ordinary aspects of care on which students can focus to help them to understand the privilege of being a nurse and the extraordinary impact they have on the person-centred care provided.

Nursing Personhood

Here I will critically explore the understanding of nursing personhood and challenges associated with examples from my practice. In clinical practice as a paediatric nurse and midwife, I commit to adhering to the revised definition of personhood by McCormack and McCance (2017). Nurses and midwives should enable people to live their life plan without us as a profession placing our values and beliefs upon them. I believe that people have inborn potential and once provided all the required information, they are capable of making their own life decisions. However, when I applied this definition of personhood to my practice as a nurse educator, and when working with students in practice, I identified limitations to the enabling of students to live their life plan. For example, I recognised from practice experiences that the profession may impose (or bestow) views of what a nurse should look like, or should behave, attempting to mould them to our vision of a nurse. This appears to reflect the Kitwood (1997) definition of personhood, where we place "a standing or status that is bestowed upon one human being, by others, it implies recognition, respect and trust". I would argue this status does not always recognise their personhood, nor is based on trust and respect. As shown earlier, in my role as DCL, I am aware of many instances where students are not valued or respected; viewed as 'not caring' or 'not as well trained for the realities of practice as use'. This suggests that registered nurses, including clinical supervisors, may not appreciate the inborn potential of the student. In Singer's eyes (Singer 1979) this would seem that registered nurses view students as

a different species bestowing them with a status as a lesser species. This personal assumption provided the impetus for further exploration within this PhD research.

An informal discussion with nursing colleagues regarding the existence of nursing personhood provided me with a variety of views and challenged my assumptions. Drawing on my philosophical explorations, I recognised that nursing personhood partly comes from within our moral conscious but is also relational and influenced by our social context and our experiences of the caring environment. From my own perspective, although I did not set out to be a nurse, it was a career I took on and discovered I enjoyed and now embody in my life.

If I relate this to the notion of a person within Aboriginal beliefs, well-being is viewed as dependent on the members of that community being able to be 'on country'; gaining nourishment from the land on which they were born (McMillan et al. 2010). I can see this relates to the nursing profession and the sense of community that is required for the learning culture to be positive to enable the nourishment of all who exist within it. The fulfilment that comes with family connections and being with others, again resonates with the sense of being within the healthcare setting, both with the people we care for and our colleagues. This sense of embodiment, innate in the Aboriginal sense of community, is essential for individual and community well-being and to enable nurses and students to reach their full potential. As a profession, I would argue that nurses should embody a way of being and enable this to influence their way of being and caring in the world. A reflection on the embodiment of personhood within the nursing profession created a sense of interest in me to explore the concept of nursing personhood. I was not able to locate any literature regarding the concept of collective nursing personhood. I would argue that the denigration of students is a symptom of a profession that lacks an understanding of our collective personhood. I have proposed that personhood is defined by oneself, therefore, in the context of the nursing profession, we have an opportunity to consider and define our unique and individual personhood.

As I discussed earlier within this chapter, person-centred care is not well understood in the context of nursing practice, however, it underpins authentic nursing practice (McCormack and McCance 2010; McCormack and McCance 2017). I would argue that nurses should consider their collective personhood and how this influences their practice to ensure they are enabled to provide person-centred care. Respecting the personhood of our colleagues and those we care for would be enhanced with a clarification of our collective personhood of the nursing culture a nurse works within. This would also improve the organisation's person-centred culture and assist in the connection of person-centred moments of practice moving to a culture of person-centredness where people were able to be innovative and flourish to their full potential (Dewing and McCormack 2017).

I propose that the nursing profession should determine our own collective nursing personhood. Sharing values and beliefs and exploring the practice culture enables debates about equality and power in nursing to be undertaken and are a starting point for exploring collective nursing personhood. Nursing personhood should be described by the profession as an expression of the Knowing, Doing and Being of nurses within a specific culture. It is essential that as part of a collective, individual nurses own their behaviours and clarify what they look like, what they feel like. This consideration enables an understanding of the experience of being cared for by someone who has embodied the espoused values of collective nursing personhood. There is a need for more evidence to provide a voice for nurses, enabling them to create a sense of personhood and increase their sense of value and identity in the nursing profession.

I recall a time when my daughter, Jacinta, came home from her clinical placement as a student in a city-based university, in a large city hospital. She stated that the feedback she received from her clinical supervisor was that she ‘looked like a nurse’. While this was said in a positive frame, and she was proud of that feedback, I immediately wondered about the criteria or understandings used by the clinical supervisor in providing that subjective description. I am confident that it was not the Registered Nurse (RN) Standards for Practice (NMBA 2016), but I am sure what she was really saying was ‘you fit here’. My assumption was that my daughter had learnt from her

previous placements how to quickly fit into the practice context. Her being proud of 'fitting in' came from a place of longing to belong rather than authenticity.

When I consider this broadly for students, I have considered that this is part of why students yearn to belong in practice (Levett-Jones and Bourgeois 2015). The clinical practice environment is complex and challenging to navigate for students. I propose that the argument for a limited understanding of nursing personhood within the profession, suggests, that as each new student enters an environment, they focus on how they can fit in as a person or mould to fit with the expectations, beliefs and values within that workplace culture. This could suggest that students behave differently in the practice environment, adapting their behaviours to fit and be accepted. Ideally, they should be empowered to flourish to be the best nurse they can be at that point in their program of study. If, as a profession, we had a collective understanding of our personhood as nurses, it would enable the judgment of students to be against the RN Standards for Practice (NMBA 2016) rather than if they belong or fit in (Levett-Jones and Lathlean 2009). Nursing personhood is explored in Chapter 12 as a key discovery with a further exploration of the link to the Aboriginal sense of collective personhood.

Chapter Summary

In summary, this chapter has assisted me as a person to consider my worldview of a person, personhood and person-centredness that I bring to this research. The poem below communicates my journey in writing this chapter. It demonstrates that I have considered person, personhood, and person-centredness from the literature and my personal nursing and life experiences.

Poem

Feeling confused

I started reading, reading, reading

I gave myself time to think, reflect, think, reflect

I started writing, writing, writing

Clarification of what is a person is or are there just more questions?

Considering personhood and how what does this mean to me?

Transforming my thoughts on person-centred care

Considering and talking through nursing personhood

Is there such a thing? I think so!

Do we are nursing know and understand our personhood individually and as a nursing community?

Does our lack of understanding lead to less moments of person-centred care?

Why do we think we have the right to bestow as status below a registered nurse to students?

Oh NO! We are crushing our future workforce.

Stop! – if we read, think, reflect and write about nursing personhood we may transform

We will stop crushing our future workforce

We have the potential to create a garden for them to grow and develop to their full potential in.

I wish for students to be the nurse they want to be not the one I want them to be.

In summary, I believe a person is a complex human being who has both a moral consciousness and mind and a body. I believe what we do as a person is influenced by our moral consciousness that is innate within us and by the social context we experience. I do not believe that our body and soul are separate, rather I believe in unity as I believe what we do influences who we are as a person. Personhood to me is determined by the person, not by others and it is living your own life plan true to your own values and beliefs. Personhood is linked to enabling others to be the person they wish to be and to flourish to their own full potential, ideally this is not imposed or

influenced by others' values and beliefs. I believe person-centred care is a way of being that is true to your values and beliefs in your interactions with people in the health care environment.

I have argued that nursing personhood exists, embodies our collective ways of being, and influences our behaviour both in the practice environment and throughout our lives. I believe that in considering their understanding of person, personhood and person-centredness, nurses as a profession can enable the future workforce to flourish. Arguably, we risk socialising students to recreate ourselves, leaving a legacy of nurses who adopt and do not challenge current workplace cultures, missing opportunities to proactively transform the environment of health care services.

Moving along the road to Chapter 5, I bring together the learnings so far from exploring my ontology, how I now understand person, personhood and person-centredness and move to consider publications that have influenced the exploratory phase of this PhD research.

Chapter 5

The Literature Exploration

Image 5-1 A Literature Exploration - © Maria Mackay 2020

Introduction

The image above (see Image 5-1) represents that my exploration of literature is comprehensive, although follows a different path than the traditional approach to undertaking a single review of the literature. This chapter outlines four publications, two of which are accepted for publication and a further two currently under review. I am the lead author in all four publications and made a significant contribution to all the publications. Two of the publications are systematic literature reviews, one other includes a comprehensive review of the literature, and one is a critique of a relevant textbook. I have endeavoured to publish throughout the PhD journey, to develop my skills in undertaking peer-reviewed publications and to disseminate research findings with my academic colleagues in a timely way. There is also another part of this thesis where further aspects of literature are explored in Chapter 6, where I share my understanding of belongingness.

The chapter begins with an overview of the exploratory phase of this PhD research where two smaller research projects informed the development of the larger research

study. The first article is a published literature review titled ‘How do we consider the impact of clinical supervisor education? A participatory literature review’ (see Appendix B). This project explored the research topic from the clinical supervisor perspective and resulted in the development of a guideline for the facilitation of learning between students and clinical supervisors in practice (see Appendix C). The second article titled ‘Enabling nursing students to participate in designing an educational resource to support their participation within clinical practice’ (see Appendix D), has been submitted for publication. This second project explored the research topic from a student perspective and resulted in the outcome of the development of a Student-led Conversation form (see Appendix E). Both projects influenced the creation of the main PhD research topic and questions, enabling me to see the need to give students and clinical supervisors an equal voice in this PhD research.

The chapter, I then critical discusses the final two publications that were focused on the methodology and methods for the PhD research. The third publication which is included in Chapter 5 was a discussion paper that has been published titled ‘Making sense of critical participatory action research. Reflections on The Action Research Planner: Doing Critical Participatory Action Research’ (see Appendix F) where I considered action research as a methodology for the research. Although I did not go on to utilise this methodology, the learnings from the exploration of researching in authentic participatory ways influenced the development of my approach to participatory person-centred research. I conclude with a final fourth publication that is a scoping review of the literature. This publication has been submitted for publication and moves the research into a person-centred methodology. The paper explores the use of Emoji as a research information collection tool titled ‘How do emoji facilitate learners within the context of healthcare education research? A scoping review’ (see Appendix G). Undertaking the scoping review enabled me to see the impact of having the courage to deeply listen to my participants. The use of emoji as a research method was an innovative and unexpectantly powerful tool to collect the larger project's information.

The Exploratory Phase of the PhD Journey

Publication 1 - How do we consider the impact of clinical supervisor education? A participatory literature review.

The initial literature review was undertaken in a participatory way and formed a small project that was undertaken over 2016 and 2017 and published in the International Practice Development Journal in May 2019. The project had two parts; the initial part was a traditional systematic literature review and the second was a participatory process where clinical supervisors reviewed the findings of the literature review and contributed to developing recommendations for future practice. This project was the first time the clinical supervisors' voices were presented in this PhD research. I undertook this initial project with one of my supervisors and an academic colleague with regard to the role of the clinical supervisor. I was the principal researcher in the project and the lead author on the publication. I took a lead role in undertaking the ethics process, completing the literature review, undertaking the participatory process with clinical supervisors and writing the publication.

The published article is included as Appendix B:

MACKAY, M., RILEY, K. and DEWING, J. 2019. How do we consider the impact of clinical supervisor education? A participatory literature review. *International Practice Development Journal*, vol. 9, no. 1, pp.1-16 [Accessed 4 November 2020]. Available from: https://doi.org/10.19043/ipdj.91.007

Clinical supervisors work with students in practice at UOW and as part of their employment, they participate in biannual education workshops. These workshops proposed to build on their current knowledge, skills and attitudes and influence their future practice. Effective strategies to educate clinical supervisors were explored within this review to gain an understanding of the existing evidence base for conducting workshops and to consider the strategies that would best enable them to be equipped to undertake their role in creating person-centred learning in clinical practice. At this point in the development of the research topic and questions, I was focusing on how clinical supervisors could enable the learning of students during a clinical placement.

My initial questions were:

1. How do clinical supervisors who practice using person-centred interventions influence learning cultures in clinical practice?
2. How do clinical supervisors who practice using person-centred interventions enable students in clinical practice to transform their learning?

There were two parts included in the literature review process. The first was a literature review using a five-step method, described by Booth et al. (2012). This was completed to explore the learning and teaching strategies that have been demonstrated to be effective in providing clinical supervisors with knowledge and skills. Four key themes were identified from the literature, they were: that education increases the knowledge, skills and attitudes of clinical supervisors; clinical supervisors believed they gained key learning by networking with others at education sessions; various modes of education support sustainable learning; and that education for clinical supervisors is required to create a positive learning culture. The second part of the literature review process was a participatory phase where the themes were validated by the thirty-six clinical supervisors. Overall, we collaboratively concluded i) that it was beneficial to have practitioners validate literature review findings, ii) there was limited evidence on the learning and teaching strategies for clinical supervisor education and iii) there was no literature on person-centred learning and teaching resources to support clinical supervisor learning and development.

Following the literature review, I worked with a colleague from UOW (Carley Jans) and the clinical supervisors who attended the education workshops in February and July 2017 to address the gaps identified. We collectively developed a guideline for clinical supervision of students in practice. A strength of the initial document was the development of a person-centred theoretical teaching philosophy to support the six steps that explained how to work as a clinical supervisor. Also, the document clearly defined the roles of the clinical supervisor. This resource guideline document addressed an identified gap pertaining to what is expected in the role of clinical supervision. I checked in with colleagues from around Australia and searched internationally, finding documents that provided broad statements on what is expected

from clinical supervisors, but nothing provided clear ‘how to’ practical advice on undertaking the role of clinical supervisor. The guideline developed was adopted by the UOW SN approach for the education of clinical supervisors, using the steps as the basis for all the education programs. On reflection, this guideline was very much focused on how to ‘do to’ rather than ‘doing with’ students in practice and has become a guideline for the clinical supervisor.

Appendix C is the latest version of the guideline used to facilitate the learning between students and clinical supervisors in practice. The focus of the guideline has progressed from the clinical supervision of students in practice to now being a guideline to facilitate learning between students and clinical supervisors in practice. The student project that will be outlined below helped me and others see that the intention of the document needed to change, identified the gaps in knowledge or evidence, and informed the larger research study within my PhD. This project was an essential first step in exploring my PhD topic and question. The clinical supervisors who participated shared their knowledge and challenged me to consider the significance of their role. I am truly grateful to them for their generosity and the vulnerability they demonstrated in sharing their experience.

Publication 2 - Enabling nursing students to participate in designing an educational resource to support their participation within clinical practice.

The second publication presented a project titled ‘Enabling nursing students to participate in designing an educational resource to support their participation within clinical practice’, undertaken in 2018 with six students in Year One of their BN (see Appendix D). This project was the first time that students were given a voice in this PhD. I gained so much from their wisdom, as this group of students helped me see the need to include them and their voice in a more authentic way in my PhD research. The project involved the students considering what a healthful relationship looked and felt like to them and what would enable them as students to be active in their supervision and assessment during a clinical placement.

The students as co-researchers, co-developed with myself and one other UOW academic staff member (Carley Jans) a student-led conversation form (see Appendix E). The form was evaluated as part of the project. The key learnings identified were a need for emotional preparation for practice to enable the creation of healthful relationships between students and clinical supervisors and, importantly, an equivalence in educating students and clinical supervisors for practice. The final finding was that by showing their vulnerability to the supervisors through the sharing of values and beliefs and fears, students felt they were better able to create human connections. See Appendix D for the full article that has been submitted for publication to The Journal of Professional Nursing. I was the project lead, facilitated the workshops to collect information and contributed significantly to the publication of which I am the lead author. The publication included a review of the literature on student participation in developing learning and teaching resources for their preparation for clinical practice.

There were many learnings for me in this project. However, the most significant was that I had spent many hours educating clinical supervisors to undertake their role and create a relationship with students. I had no awareness that I should be doing the same with the students. The findings from this second publication were incorporated into the UOW BN in Year One and were evaluated as part of the PhD research. The evaluation from students and clinical supervisors who experienced the curriculum change is explored further in Chapter 8 and Chapter 9. In these chapters, information collection and synthesis, they share their experiences and how this prepared them to create relationships and to realise their full potential. Another learning for me was that I had not considered the student voice in developing the guideline for supervision in practice and that the language itself was too focused on ‘doing to’ students. The guideline (see Appendix C) has been reviewed twice and the final review had input from students and will include additional student voices in future revisions. I will forever be grateful to the wonderful students who not only gave their time and wisdom but also patiently helped me gain a new learning perspective on the value that the student's voice has in co-developing curriculum. This project gave me confidence that students in the first year of their BN were the right choice for this research.

The research topic and question evolved as an iterative process and from the two research projects where a gap emerged regarding creating healthful relationships and their influence on transformational learning in practice. Additionally, my understanding developed of the need for this research to hear the voices of both students and clinical supervisors to create a shared story for us to learn from together. The final topic and questions were:

PhD Research

An exploration of how healthful relationships between students and clinical supervisors influence transformational learning: a person-centred inquiry.

Research question

How do healthful relationships between students and clinical supervisors influence transformational learning?

Methodology and Methods

Publication 3 - Making sense of critical participatory action research. Reflections on The action research planner: doing critical participatory action research.

In 2016, I completed a reflection on my learning from reading the book 'The Research Planner: Doing Critical Participatory Action Research'. This reflection came at a point where I was considering methodologies that may be suitable for my PhD research project. Although I did not eventually utilise action research, I did learn from exploring the methodology and completing this publication. In this paper, I am the only author and reflected on how the book 'The Research Planner: Doing Critical Participatory Action Research' enabled my understanding of participatory research in the critical paradigm.

The paper was published in the International Practice Development Journal, 16 November 2016. It is attached to this thesis as Appendix F.

MACKAY, M. 2016 Making sense of critical participatory action research. Reflections on The action research planner: Doing critical participatory action research. *International Practice Development Journal*, vol. 6, no. 2, pp.1-3 [Accessed 4 November 2020]. Available from: https://doi.org/10.19043/ipdj.62.013

This is the shortest of all the publications however, many lessons were learned from the consideration of Critical Participatory Research. I gained a deeper understanding of the concept of participation in research from a critical and authentic perspective and began to ponder how to include participation within the planning phase of this research prior to the submission of ethics. I developed an approach to working with potential participants and this was used within the second project based on enabling students and the final PhD research. I found the challenge of how to be participatory from planning my research through to the dissemination of information an interesting concept, and was perplexed as to how to include participants prior to ethical approval. To overcome this, I undertook a workshop with potential participants. Potential participant were students and clinical supervisors who would have been eligible to participate at the time of planning. In the workshop, we considered the research topic and question. Next, the potential participants worked in groups to consider how we could collect information to answer the question and how we could make sense of the information collected. Finally, the groups collectively shared their information and considered if what we had agreed to do would enable the participants and co-researchers to be active in their participation. Further information on this is included within Chapter 8 where I explain the theoretical aspects and application of the methods.

The other significant learning was that I increased my understanding of research within the critical paradigm and how this relates to Habermas's (1987) concepts of communicative action and communicative spaces to the public sphere, safe spaces and mutual consensus (Kemmis et al. 2013). This part of my journey demonstrates that as a PhD student I should consider different research approaches to gain a broad understanding in developing the methodology for my research. As discussed in Chapter 7, my chosen methodology was inherently participatory by being embedded within the principles of person-centred research.

Publication 4 - How do emoji facilitate learners within the context of healthcare education research? A scoping review.

The final publication I completed as part of this research was a scoping review titled

‘How do emoji facilitate learners within the context of healthcare education research? A scoping review’. This review was completed with the aim to elicit what was known about the use of emoji as a method or an information collection tool in health education research. I undertook this review with two of my supervisors who provided a form of triangulation or validation throughout the scoping review process. I took the lead in undertaking the scoping review which utilised the process described by Arksey and O'Malley (2005) and enhanced by Levac et al. (2010). The review was undertaken as emoji was chosen as a method when potential participants and I needed to further understand their use in research and particularly in health education research. The publication has been accepted for peer review within Contemporary Nurse and attached to this thesis as Appendix G.

The literature identified was largely at the expert opinion level. The information that was included was minimal with seven articles identified as suitable for inclusion in the review. The scoping review identified four themes and they were: i) semiotics of emoji; ii) cultural and contextual influences on the emergence of emoji in healthcare research; iii) the emergence of emoji as a research method, and iv) a tool for the facilitation of learning. The recent popularity of emoji in digital communication has also given rise to its popularity for use as a tool for research information collection. Chapters 8 and 9 provide further information and exploration of how the use of emoji as an information collection tool was a powerful medium along with the inclusion of Dadirri, enabling participants to connect with their emotions and share what they experienced from creating relationships with each other in practice. Emoji in the scoping review was demonstrated to increase a person’s emotional connection with others. The conclusions reported that there was a paucity of information in the literature on the relationship between the use of emoji and person-centred research.

In reading the articles included within the scoping review, I learnt so much about the history of emoji, which originated in Japan in 1997 and emerged from the original emoticons. I gained insight into how the use of emoji has brought a connection to emotion into our communication from a historical perspective. I was unaware of how the written word purposefully took the emotion out of our communication. This related

emoji well to the PhD research as we used them to collect information on how the relationship was experienced from a positive and challenging perspective. In considering the relationship of emoji and person-centred research, connectivity is a principle within person-centred research and therefore the creative use of emoji provides a connection to self-awareness and embodied knowing (Jacobs et al. 2017).

Chapter Summary

This chapter has provided a discussion about the four publications I completed as part of my PhD journey. In summary, this chapter is a non-traditional approach to engaging with the relevant literature that has informed this PhD research. The findings presented in this chapter and the attached publications have provided knowledge and understanding for the development of the final research topic and questions shared in the subsequent chapters in this thesis. The methodology is described in Chapter 7, methods and information collection in Chapter 8 and information synthesis and meta-synthesis being outlined in Chapter 9.

The completion of four peer-reviewed publications has contributed to my development as a person-centred researcher. I gained valuable skills in literature searching within academic databases, critical appraisal of literature, writing for publication, and the publication process. Also, I gained experience in working in participatory ways that informed the approaches taken in the final PhD research project. I have also been able to disseminate the knowledge that has been developed as part of my PhD research before the thesis submission with my colleagues and internationally.

The poem below shares my learnings from the process of undertaking literature reviews, completing projects and publication in peer-reviewed journals:

Poem

Trusting the process
Two small projects informing how I see and understand
One helping to see the wonder of collaboration helps me understand
The other helping me to see that listening and learning enables me to understand
Seeing the world through other eyes to now understand

Trusting the process
Writing about methodology may be useful
Even if the methodology changes learning is useful
Using emoji to collect information is useful
Learning about how others use emoji is useful

Trusting the process
Trusting the process is vulnerable
Trusting the process is brave
Trusting the process takes courage
Trusting the process is useful to help me understand

Moving along to Chapter 6, I bring with me my understanding of myself as a person-centred researcher, with the concepts of person, person-centredness and personhood enabling me to consider the research paradigm and theoretical underpinnings of this PhD research. I mention several times in this thesis that I have feelings of uncertainty and vulnerability at each point of the PhD journey. Moving along the road to developing a theoretical framework, I began to appreciate the knowledge and understanding I was acquiring as this enabled me to move forward and embrace the next part of the PhD journey.

Chapter 6

Taking the Road to Developing a Theoretical Framework

Image 6-1 Taking the Road to Developing a Theoretical Framework - © Maria Mackay 2020

Introduction

I provide an overview of the ontological and epistemological principles that informed the development of the theoretical framework for this PhD research within Chapter 6. The image above (see Image 6-1) represents the part of the road where I paused to consider and reflect on the epistemological underpinnings of this thesis. I begin the chapter with an overview of critical realism indicating how this fits with the PhD research. Critical realism allows for the creation of new meaning and understanding through exploration. I believe this fits with this PhD research's aim in creating a shared understanding of how healthful relationships influence person-centred transformative learning in practice. Further, within this chapter, I have critiqued several philosophical and theoretical perspectives and brought them together within a Philosophical Collage (see Image 6-2 below) to represent my theoretical underpinnings of this thesis. This iterative process involved moments of creativity, critical dialogue and reflection to describe an approach to transformational and thus person-centred learning in clinical practice. These perspectives are critical theory (Habermas 1987), transformational

learning (Mezirow 1978), the Person-centred Practice Framework (McCormack and McCance 2017), and belonging, from the perspective of freedom (Angelou and Elliot 1989). The theoretical framework development informed the lens for exploring the research question, how do healthful relationships between students and clinical supervisors influence transformational learning?

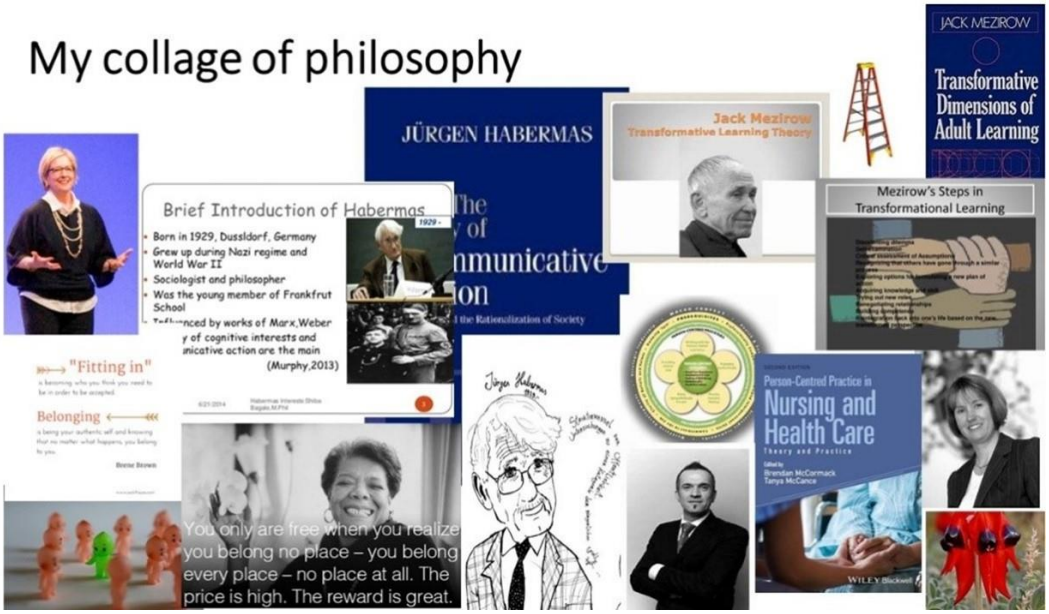


Image 6-2 Philosophical Collage (2017)

Where I initially sought to find one philosopher that would fit with my values and beliefs, I soon realised that no one person or theory was adequate in reflecting my beliefs and research context. I felt more comfortable as I moved to consider the gems from many philosophical and theoretical perspectives and believe I have developed a richer theoretical understanding through this critical collation of several perspectives. This enabled me to create the theoretical framework (see Image 6-3) that informed the research process. The picture in the bottom right-hand corner of the image (see Image 6-2) is of the Sturt Desert Pea. This is a wildflower from Central Australia that grows in places where it does not rain for many years. This wildflower has evolved to have a hard shell surrounding the seed, enabling it to lie dormant in the sandy ground for up to 12 years. It only takes a few drops of water the seed is germinated and this beautiful flower blooms (Symon and Jusaitis 2007). This to me symbolises human flourishing, an example in my personal journey has been a journey from being dormant (or theory

being unknown to me) to a sense of flourishing as I critically explored the philosophical and theoretical underpinnings of this PhD research.

Ontology - The Critical Realism Paradigm

In this section, I explore the ontological perspective of this PhD research. As defined by Kivunj and Kuyini (2017), Ontology requires clarification at two points in the thesis. Initially, I have in Chapter 3, unpacked my personal ontology or assumptions through an exploration of my values and beliefs. Secondly, these values and beliefs will be further examined through unearthing the ontological assumptions of critical realism. I will then explain how myself and others as co-researchers utilised this to make sense of the reality and essence of the social phenomena of the relationship between students and the clinical supervisors (Kivunj and Kuyini 2017). "At the core, ontology is the study of what we mean when we say something exists" (Dewing et al. 2017, p. 20).

Ontologically, critical realism informs the way I understand the world and the way this research understood the persons within it. As co-researchers, we were required to have an understanding of how our worldviews influenced the overall PhD research (Titchen et al. 2017). Critical realism is a post-positivist perspective of exploring science and suggests that ontology predisposes methodology (Bhaskar 2008). As a person-centred researcher, I believed this point was significant; understanding how I see the world and reality was important for me to understand before I moved to actively undertake any research. Critical realism proposes that making sense of society and social processes, ensures individual needs are appreciated for their contribution to the natural world. In the clinical practice context, this enables us to recognise each healthcare setting as unique, with its own worldview that should be considered and respected when exploring the culture. From this, we consider how individuals within a specific context are influenced. Within this ontological perspective, the research outcomes are relevant to the context of the research, are not necessarily generalisable, but provide useful information for the exploration of this research in other areas.

Realism as an ontological concept can be simply defined as "an attitude of considering

some entities as really existing" (Italia 2016, p. 21). There are several views of realism (Easton 2010), however, realism from a philosophical perspective considers objectivity as an absolute in the principle of objective truth and objective evidence (Wilson and McCormack 2006). Realism proposes an antipositivist view of science where the realist looks objectively at the world rather than immersing themselves into it, considering it with the lens of vision and creativity (Mingers 2014; Wilson and McCormack 2006; Easton 2010). In redesigning a realist perspective of the world, Bhaskar (2008) argues there is a shift from the realist understanding that truth is found in objectivity to where objects act independently of each other and there is no one truth (Bhaskar 2008). He further argues that people or objects act independently of each other and that events would occur even if they were not observed; therefore, things occur in the world, regardless of the observer (Mingers 2014; Bhaskar 2008).

Critical realism is a contemporary paradigm with Roy Bhaskar being heralded as one of the founders of this philosophical perspective (Mingers 2014). His PhD thesis was the foundation for a seminal text, 'A Realist Theory of Science' which has provided the initial consideration of the development of critical realism in what he described as transcendental realism (Bhaskar 2008). Easton (2010) argues that critical realism is a modern approach to ontology, epistemology and axiology. He further considers that "critical realism assumes a transcendental realist ontology, an eclectic realist/interpretivist epistemology and a generally emancipatory axiology" (Easton 2010, p.119). Axiology in this sense is the emancipatory approach to the study of value or the concept of worth (Kivunj and Kuyini 2017). Roy Bhaskar's perspective of critical realism is criticised for a lack of clarity and rigour. Bhaskar is argued to have limited academic research in his writing (Collier 1994). Value and worth within this PhD research sits in the consideration of exploring how we value or consider the worth of both students and clinical supervisors in developing healthful relationships.

Below in Table 6-1, I outline my values and beliefs and the ontological underpinnings of critical realism according to Sayer (1992). In the table, I highlight the relationship between critical realism and critical theory, and the independence of the social world and the natural world (Habermas 1987). Further, critical realism purports that the real

world cannot be observed, instead, the world as we experience it (observed world) exists as a construction from our experiences and perceptions (Archer 1988).

I believe congruence is evident; I see ontology before methodology and value the worth of others from a caring perspective that is both innate and learnt. I value persons as experts in their own lives, reflecting the ontological perspective of existence being independent of observation. Within the concept of axiology or value and worth, each of us has a unique worth that can be explored. The findings of this sit independently, however, there is a stratification that occurs in the complexity of our being and our need to connect through relationships. Easton (2010) argues that Sayer's assumptions 1, 4 and 5 form the basic assumptions of critical realism whilst 2, 3, 6 and 7 accept that reality is socially accepted. My personal ontological values and beliefs and assumptions (as explored earlier in Chapter 3) align with the underpinnings of critical realism and are restated below in the first column of Table 6-1.

My Personal Values and Beliefs	Critical Realism Underpinnings
I believe: • I experience the world of nursing through the lens of a paediatric nurse • A person's experience of family and culture influences their personal and professional way of being • Caring is an art and is innate within me and others, and contributes to the teachable moments to be learned and developed over time • It is a challenge for the nursing profession to consider how we bridge the gap between university education and clinical practice for students	• The social world is intrinsically different to the natural world, • Ontologically social objects do not exist in the way physical ones do (i.e., as subject independent), and that epistemologically there is no possibility of facts or observations that are independent of actors, cultures or social practices. (Habermas 1987)

My Personal Values and Beliefs	Critical Realism Underpinnings
I value that: • Registered nurses need to have the ability to enable people in our care to be active in decision making and experts in their care • Registered nurses have the influence to enable the development of high-quality nursing practice • The skills and attributes that university educated nurses bring to the profession are valuable • Creativity helps to unlock hidden knowledge and this creates a unique learning space • When we interact with others, we need to respect learners are experts in their own educational journey • Person-centred care at the point of care is achieved when nurses themselves feel cared for and valued	Sayer sets out what he regards as the 8 key assumptions of Critical Realism: 1. The world exists independently of our knowledge of it. 2. Our knowledge of the world is fallible and theory-laden. Concepts of truth and falsity fail to provide a coherent view of the relationship between knowledge and its object. Nevertheless, knowledge is not immune to empirical and its effectiveness in informing and explaining successful material practice is not a mere accident. 3. Knowledge develops neither wholly continuously, as the steady accumulation of facts within a stable conceptual framework, nor discontinuously, through simultaneous and universal changes in concepts. 4. There is a necessity in the world; objects—whether natural or social—necessarily have particular powers or ways of acting and particular susceptibilities. 5. The world is differentiated and stratified, consisting not only of events, but objects, including structures, which have powers and liabilities capable of generating events. These structures may be present even where, as in the social world and much of the natural world, they do not generate regular patterns of events. 6. Social phenomena such as actions, texts and institutions are concept dependent. We not only have to explain their production and material effects but to understand, read or interpret what they mean. Although they have to be interpreted by starting from the researcher's own frames of meaning, by and large they exist regardless of researchers' interpretation of them. A qualified version of 1 therefore applies to the social world. In view of 4–6, the methods of social science and natural science have both differences and similarities. 7. Science or the production of any kind of knowledge is a social practice. For better or worse (not just worse) the conditions and social relations of the production of knowledge influence its content. Knowledge is also largely—though not exclusively—linguistic, and the nature of language and the way we communicate are not incidental to what is known and communicated. Awareness of these relationships is vital in evaluating knowledge. 8. Social science must be critical of its object. In order to be able to explain and understand social phenomena we have to evaluate them critically (Sayer, 1992, p.5).

Table 6-1 Ontological Assumptions - (Habermas 1987; Sayer, 1992, p.5)

Fay (1987) argues that all paradigms have value and as a society, we need to have research undertaken from all perspectives. Although Fay sits within the critical theory perspective, he proposes that an appreciation of a range of research paradigms and methodologies is required to fully explore the world we live in. In determining my fit with critical realism, I considered other paradigms however they did not fit with my values and beliefs and this PhD research. Persons from a positivist perspective argue for causality and generalisable findings to prove or demonstrate the causal link and truth (Kivunj and Kuyini 2017). Persons who take a positivist and interpretivist perspective advocate researchers should be independent of the research and remain objective in the analysis and interpretation of data and findings (Easton 2010 and Kivunj and Kuyini 2017). Alternatively, from a critical perspective, the researcher refutes reality and discards the need to recognise causality (Easton 2010). For my PhD research, there were many variants, and a critical perspective enabled this PhD research to focus on exploring what was reality and opened up what was possible rather than accepting one reality (Kivunj and Kuyini 2017). I, along with the co-researchers, sat within the research and our assumptions, values and beliefs were overt and assisted in the overall interpretation of the information we explored.

In summary, I locate myself in the critical paradigm for this PhD research with an ontological emphasis on critical realism. The relationship between critical realism and critical theory lies in the realist interaction of the influence of society and culture. Some argue there is a relationship and that Jürgen Habermas is in fact an honorary critical realist (Strydom 2007). Bhaskar, however, does not agree there is a relationship, rather that critical realism stands alone (Strydom 2007). Critical Social Science has similarities to the concepts of critical theory. Fay (1987) argues that it sits separately from other critical theories in that its emphasis is on science from a broad perspective, and distancing critical social science from the work of the Frankfurt School, a School well known for social theory and critical philosophy at Goethe University in Frankfurt

Taking a critical realist ontological approach to this PhD research provided a values-based platform for exploring the real world of clinical practice. The relevance of critical realism focused on the relationships between student and clinical supervisor,

in the here and now. The findings from this exploration were relevant to the persons involved in real time, the context of curriculum and the specific care environment from which they evolved. Learnings in the PhD research came from a stratified exploration of the micro and mezzo context of care that is directly influenced by the macro context (McCormack et al. 2010). Ontologically, my values and beliefs include having authentic participation where the group of co-researchers' value each other's worth and contributions. I believe that the world exists with multiple realities and through ontological values-based research approaches, we can begin to understand the specifics of each reality. I believe what is gained from this PhD research is relevant to the context it is discovered within. Fundamentally, this PhD research is an exploration of the influence of person-centred transformative learning for each student and clinical supervisor. Although influencing other contexts is not a focus or driver for the PhD research, the learnings or outcomes may inform future practice and research.

Philosophical and Theoretical Influences

In this next section of the chapter, I will explore the epistemological assumptions of this PhD research. Epistemology originated from the Greek word 'episteme' meaning knowledge and is defined as the knowledge behind how we know and understand the world (Kivunj and Kuyini 2017). In understanding how healthful relationships are created and influence person-centred transformational learning, I have developed a theoretical framework, Person-centred Transformational Learning in Clinical Practice. This framework has been influenced by a creative process where I co-mingled the assumptions I had developed from several philosophers and theorists. These influences included (Habermas 1987) communicative action theory, transformational learning (Mezirow 1978), the person-centred framework (McCormack and McCance 2017) and belonging (Angelou and Elliot 1989). Through exploration and consideration of all the influences in the light of critical realism as described above, I have co-mingled the salient points of their work that resonated with me as their gems and created a theoretical framework (see Image 6-3) that informs the development of clinical practice learning in a person-centred transformative curriculum at the Bachelor of Nursing level. It can be argued that person-centred learning is inherently transformative. Although I agree there is an element of transformation in person-

centred learning, I believe that by having the two concepts sit separately, the true essence of transformational learning and person-centredness are valued and respected. I have explored the concepts of transformational learning and could not identify a framework that provides knowledge and understanding of transformational learning in the context of clinical practice. Mezirow's research and evidence supports transformational learning in the form of curriculum and somewhat moves this to a teacher based educational classroom setting (Mezirow 2009). Hardiman and Dewing (2019) provide a framework for person-centred learning in the clinical setting titled 'Critical Allies and Critical Friends'. This work has influenced my thinking with regard to learning in practice, however, their research is based on registered nursing learning from each other in the context of their practice and their own workplaces. Although there are synergies with other frameworks, I believe the context of pre-registration curriculum requires research in the area of person-centred transformational learning to enable the future workforce to be transformative person-centred practitioners who are able to respond and react positively. The theoretical framework titled Person-Centred Transformational Learning in Clinical Practice (see Image 6-3) attempts to address how to enable learning between students and clinical supervisors in the reality of practice.

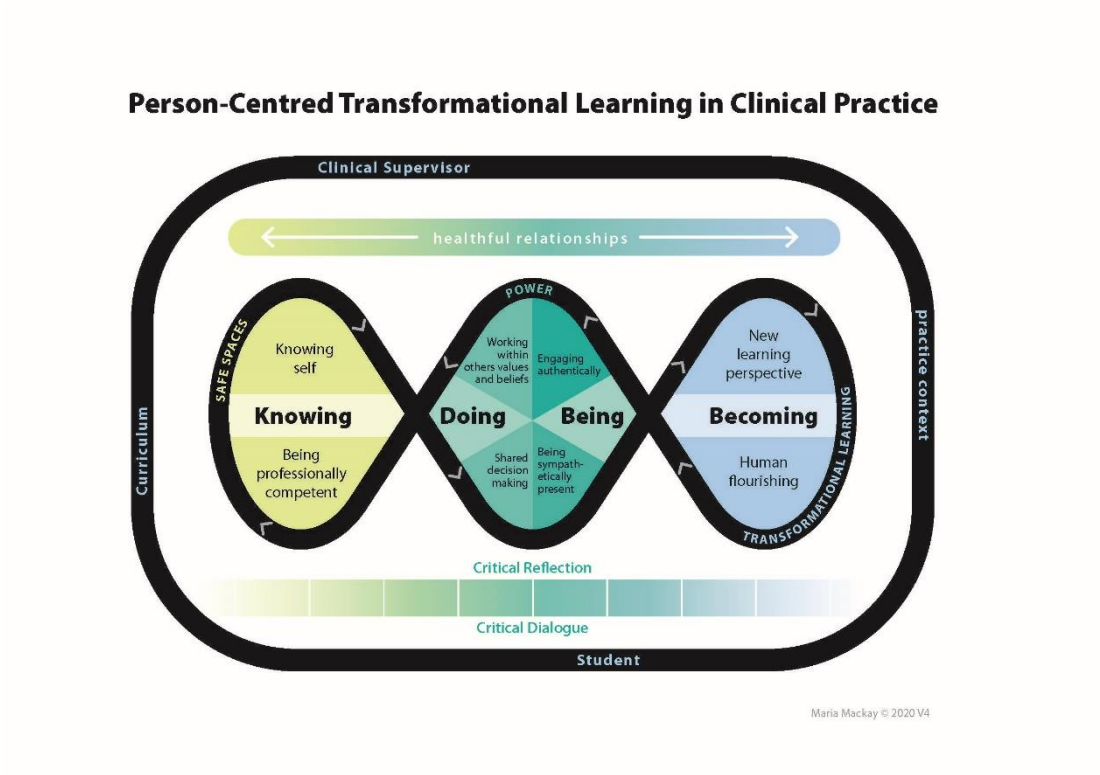


Image 6-3 Person-centred Transformational Learning in Clinical Practice (Final Version 2020)

The philosophical and theoretical influences are embedded within the theoretical framework above (see Image 6-3), specifically within the concepts of Knowing, Doing, Being and Becoming. There are many variations seen in the literature about how Knowing, Doing, Being and Becoming are ordered (Wilcock 2002; Duchscher 2008; Ewing and Smith 2008). I believe that in undergraduate pedagogy and curriculum development, Knowing comes before Doing, Being and Becoming. In this framework, Knowing refers to knowing self and being professionally competent (McCormack and McCance 2017) and is essential to ensure quality and safe practice as a student and clinical supervisor (outer circle of the framework). Doing and Being are interrelated concepts that occur in the practice setting. Becoming occurs when people flourish to their full potential, a potential they determine themselves as they have the inner genius within them (Dharma), that is their own expertise in determining their own potential (Bhaskar 2008). Bhaskar (2008, p.17) in describing knowledge from a transcendental realist perspective, argues that knowledge is the output of the production of science, as "an ongoing social activity in a continuing process of transformation". The 'Person-centred Transformational Learning in Clinical Practice'

Framework has considered Bhaskar's (2008) conceptual idea of knowledge. Knowing in this framework is having the knowledge required to commence a clinical placement from both an art and science perspective. Further, knowledge is gained by 'Doing and Being' in practice, when moments of learning come together, enabling learners to create a new learning perspective (Mezirow 1978) or experience Becoming as a process within transformational learning.

I will now explore each of the concepts that have influenced the theoretical framework's development in more detail.

Communicative Action Theory – Jürgen Habermas

Communicative Action Theory was developed by Jürgen Habermas, who was born in Germany in 1929. He is known as a social philosopher and is associated with the second generation of the Frankfurt School. Habermas produced an extensive and varied range of writings and is best known for his work on critical theory and pragmatism (Roderick 1986). Within a sociological and political philosophical perspective, critical theory was developed by philosophers within the Frankfurt School and is focused on a reflection and critique of society and culture (Roderick 1986). Habermas (1987) argues that critical theory focuses on the emancipation of human beings. Habermas proposes that society depends on the criticism of itself, as it is through this critique, a person begins to understand themselves within society (Roderick 1986). For this PhD research, the core idea I chose to focus on from Habermas's work was communicative action theory and the influence that labour, communication and emancipation have on the development of society and culture. Finally, the relevance of the public sphere and the importance of the creation of safe spaces was considered (Roderick 1986; Baynes 2016) and is further explored later in Chapter 7 when exploring who will be participating in this PhD research.

Roderick (1986) states there are three critical interests in Habermas's communicative action theory. The first critical interest is labour. Labour in this context is an instrumental exercise that is defined as being a monological (or only having one powerful voice) and influential endeavour (Roderick 1986, Baynes 2016). Habermas

initially described labour as the 'sciences' or technical side of seeing the world which he believed was less informative. Later in his work, he reconsidered these ideas, conceding that where the sciences may be informative, they were not the only worldview, but are also a form of knowledge that informs society (Roderick 1986; Susen 2009). A criticism of Habermas's work is that it is elitist and does not consider the underprivileged people in society (Baynes 2016; Susen 2009). Habermas disputes this criticism and argues that his work was inclusive of workers at all levels as a fundamental belief within this theory was that enlightenment is only achievable through participants all having an equal voice (Finlayson 2005). He recognised that achieving enlightenment may be utopic, acknowledging that money and power distort communication in our everyday lives. Habermas advocated that power differences should be considered in order to move towards a state of undistorted communication (Roderick 1986; Habermas 1987). Consideration of power and the assumptions we make in our everyday interactions is significant within this PhD research, for example, given that students are in practice to translate their theoretical knowledge into practice, the assessment component of their experience creates a power imbalance between the student and the clinical supervisor who undertakes the assessment. The clinical supervisor's role in the assessment of students results in them having a perceived power imbalance and, I would argue, can lead to conversations being distorted. Power should be utilised as a positive influence to develop an environment where undistorted communication is possible (Roderick 1986; Habermas 1987). A consideration within this PhD research was the creation of person-centred learning cultures that enable conversations that espouse relevance, truth, sincerity and morality (Roderick 1986) and transformative learning to be realised.

Communication is the second critical interest. Within the theory of communicative action, the concept of rationality is described by Habermas, as in everyday life humans have an impetus to be reasonable and to provide reasons for their actions and beliefs (Habermas 1991; Roderick 1986). Habermas argued that through our interactions with each other we strive to give answers and explain why we behave in certain ways. He believed that in daily life we have a desire for consensus and mutual understanding in our discourse and communication (Roderick 1986; Baynes 2016). As a species, we

have a deep-seated interest in communicating with one another in a way that is undistorted and clear. This critical interest is relevant to this PhD research where undistorted communication is a significant consideration, as the communication between students and clinical supervisors needs to be undistorted to enable the crafting of healthful relationships. In undistorted communication, everybody has an opportunity to speak and to be heard. Habermas considered systematically distorted communication as the block that prevents clear communication, believing that in our interactions with others, human beings are able to be persuaded to change our minds through another person providing us with a more logical argument (Roderick 1986; Baynes 2016). As human beings, we attempt to ensure our contribution to conversations relevant, true, sincere and moral (Habermas 1991; Roderick 1986).

The discourse between students and clinical supervisors aims to be person-centred and achieve consensus and mutual understanding. The complexity of the practice context requires students and clinical supervisors to undertake conversations that endeavour to change their worldview by offering rational alternatives and enabling students to develop their own solutions to issues raised (Roderick 1986; Baynes 2016). The fundamental premise that is argued in this form of communication is rationality; this is also one of Habermas's communicative action theory's greatest criticisms in that it assumes all people to be rational and open to hearing a rational alternative. Finlayson (2005) argues that society at large is not rational and that there are few moral norms left in society that affect the ability to create a mutual consensus. Habermas accepts the criticism but refutes that we need to believe people are rational (Roderick 1986).

This premise of rationality was included within the theoretical framework, as an underpinning ontological and epistemological assumption is that persons have within them what they need to flourish to their full potential and therefore are rational. Aligned with my values and beliefs, I believe that learners (including students, buddy registered nurses and clinical supervisors) have the capacity to influence the learning of others and that of both the clinical supervisors. I may not agree with the choices that others make. However, that does not necessarily mean they do not possess rationality and that they are not able to make a decision that is best for themselves. Therefore, my

starting point in this research was to proceed on the belief that all persons possess the capacity for rational communication.

Emancipation is one of the values of critical theory and Habermas's third critical interest. Habermas (1987) has described emancipation as an ongoing struggle for reflective understanding. He argued that the capability of an emancipated society is measured in how we enable self-reflection, enlightenment, and censor society's capacity to control and suppress (Susen 2009). Emancipation can be described as freeing ourselves from labour distortion and communicative reasoning; however, this does not mean we are free from power and authority, rather we are free from oppression. An emancipated society is enlightened to labour more humanly and communicates freely and openly according to Roderick (1986). Emancipation related to oppression is important to consider both for the nursing profession and for students in clinical practice. I have argued within Chapter 4 that nursing personhood is not well understood amongst the profession, and many would suggest this is related to nursing being an oppressed profession, with this oppression historically being attributed to our medical colleagues. In Chapter 4, I argue it is the historical oppression of the profession that has contributed to nursing viewing students as a lesser species (Singer 1979) or bestowing a status onto them that is less than that of a registered nurse (Kitwood 1997). The concept of emancipation as described by Habermas then becomes a critical factor in the creation of safe spaces that allow for undistorted communication to occur and for discourse in the sense of argumentation, consideration of power imbalance, equity in communication and emancipation. Habermas's communicative rationality theory has values of relevance, truth, sincerity and morality (Roderick 1986). This is consistent with the values that I bring into this research where I place an emphasis on working in partnership with others authentically and sincerely. I believe transformational learning occurs when communication is considered from an undistorted perspective and value is seen in the personhood of both parties in a healthful relationship.

Transformational Learning Theory - Jack Mezirow

Jack Mezirow was an emeritus American Professor who was born in 1923 and died in 2014. He was known for his work in education and most notably for the development of transformative adult education learning theory. Major influences in Mezirow's development of ideas were Paulo Freire's (Freire 1996) concept of conscientisation particularly consciousness raising, the theory of transformation developed with Roger Gould, Jürgen Habermas, Harvey Seigal and Mezirow's wife Edee Mezirow (Brookfield 1995). Meirow began his interest in adult learning when his wife returned to education in her midlife and used this experience to develop and expand on transformational learning theory. Mezirow (1990) explored the concept of transformational learning in considering how adults learn and how this is undertaken (or facilitated) in a way that enables previous knowledge and experience to be validated and built upon. He rationalised that as adults, we have a learning perspective that has been developed from our previous life experience including the society, we live in. The lens we have today is referred to as our current learning perspective. For me this is my ontological *self* or the 'sum total of who I am' today, arising from the threads (including their knots and frays) that have made the 'I' (Kockelman 2013, p. 173) which were explored in Chapter 3. New learning and experiences challenge our current learning perspective which is experienced as a challenge or a disorienting dilemma. A disorientating dilemma can be defined as the catalyst for perspective transformation (Mezirow 1990). From this, we then develop a new learning perspective. Disorientating dilemmas are experienced by both students and clinical supervisors in the complexity and reality of practice.

Transformational learning is significant in all aspects of learning in a pre-registration nursing curriculum. This PhD research and thesis is particularly focused on pre-registration learning whilst students and clinical supervisors are immersed in the clinical practice setting. Transformational learning from Mezirow's perspective provides the student and clinical supervisor with the opportunity to create new knowledge and perspectives in practice, as it acknowledges that it is through the complexity of practice that they face disorienting dilemmas which are the catalyst for transformative learning. The ten steps below provide a framework for learning to

occur and importantly integrated within the phases is critical dialogue and critical reflection (Mezirow 1978). Significantly for this PhD research, Mezirow's (1978) transformative learning theory prescribes a process for all learners to utilise when faced with challenging disorientating dilemmas throughout their education. This theory proposes that learners have assumptions and perspectives that require unpacking through a process of critical reflection. Critical reflection in this perspective is built on from the work of Habermas (1987) in that the unpacking of the assumptions learners hold through critical discourse enables the creation of new learning perspectives and translation of reflections into actions (Mezirow 1990). It is this process of reflection that enables the emancipation of self and society at large. I believe it is the concepts of critical reflection and critical dialogue that provide both students and clinical supervisors the ladders they need to come out of the disorientating dilemmas and create new learning perspectives or as I have referred to above, to 'Become' and flourish to their full potential.

Mezirow's influence by Habermas was from a communication perspective encompassing his work in instrumentation and communicative learning (Mezirow 1990). Instrumental learning in this context is defined as managing the person and the environment, in which the learning is a one-way teacher dominated discourse (Mezirow 1990). Communicative learning is more focused on learning for meaning involving discourse that is dialectic, reflective and critical in nature. In communicative learning, people participate freely and fully, and communication is undistorted with the opportunity for equal participation to raise the consciousness of assumptions (Mezirow 1990). Therefore, learning is fundamentally a willingness to seek understanding, mutual consensus and, through argumentation, new perspectives are gained. Mezirow (1978) proposes that a dynamic learning process is a transformative process that enables learning through elaborating on existing meaning schemes, creates new perspectives which in turn generate new learning perspectives. Transformative learning is therefore embedded in learning from experience, where reflection provides the conduit to transformation or the development of new meaning (Mezirow 1990). The ten phases of learning below in Table 6-2 outline Mezirow's process for transformational learning.

Ten phases of learning (Mezirow 2009, p.19):
1. A disorientating dilemma 2. Self-examination 3. A critical assessment of assumptions 4. Recognition of connection between one's discontent and the process of transformation 5. Explorations of new roles, relationships, and action 6. Planning a course of action 7. Acquiring knowledge and skills for implementing one's plan 8. Provisional trying of new roles 9. Building competence and self-confidence in new roles and relationships 10. A reintegration into one's life on the basis of conditions dictated by one's new perspective.

Table 6-2 Mezirow's (1991) Steps for Transformational Learning

Transformative learning theory as described by Mezirow (1978), occurs when learners transform their learning perspective (or see their world differently) by creating an awareness of and reflecting on, their habitual ways of knowing (meaning schemes) and their interpretation of assumptions (meaning perspectives). A person's habit of mind is thought to be subconscious and influenced by the assumptions that have formed over time to create their habitual way of thinking. Mezirow (1990) argued that habits of mind represent the interpretation of how we see and experience society. Transformation of self occurs when a person is faced with a disorienting dilemma; though feeling challenged and undertaking a process of critical reflection this person remains open to consider new perspectives. Emancipation of individuals and society is achieved through transformational learning, and this can be sudden or occur incrementally over time (Mezirow 1990).

Mezirow (2009, p.93) examined an element of his transformative learning theory where reasoning is realised as "advancing and assessing a belief" as dialogical or communicative. Transformative learning in this context is "an adult dimension of

reason assessment involving the validation and reformulation of meaning schemes" (Mezirow 2009, p.93). He proposed that his theory's key elements include critical reflection on assumptions and discourse to validate the considered judgment. Transformative learning in society emphasises how to take the appropriate action to develop new understanding through democratic social action. I originally explored the work of Brian Fay (1987) and, although his theory of crisis also proposes that it is through the crisis you are enlightened, emancipated and empowered, it does not provide any ladder to assist with the transformation. I believe a concern with Fays' (1987) theory of crisis is that you could be dwelling in crisis for some time before the transition to enlightenment, empowerment and emancipation occurs. I believe ethically it is not reasonable to allow anyone to dwell and not offer the ladder to help them develop their own solutions to their disorientating dilemma. Although I have stated in my values and beliefs that people have within them what is required to develop these solutions and flourish, I would argue that in a two to four-week clinical placement students and clinical supervisors require these ladders to move through Knowing, Doing, Being and Becoming within the context of clinical practice (see Image 6-3).

Howie and Bagnall (2013) described four levels of criticism of Mezirow's transformational learning theory. The first criticism is based on the rigour of the research and therefore the validity of the assumptions that form the theory (Taylor and Cranton 2012). The second criticism is similar to that of Habermas with regard to rationality; there is criticism that people may not have the cognitive capacity for transformation (Merriam 2004). I fundamentally do not agree with this criticism as this is in contrast to my beliefs that people have inherently within them what they need to flourish to their full potential. Further, this does not align with my belief that people are able to determine their own personhood. The third criticism is that it does not add anything to what is already known in a modernist and emancipationist context as a theory. The final and fourth critique that Brookfield (2010) argues is that the word transformative is meaningless in the context of learning. Overall, Howie and Bagnall (2013) summarised the critiques as being commentary rather than robust critiques and issues to which Mezirow should have responded to but failed to in his ongoing work

and writing. Brookfield (1995) responded to many of the criticisms of Mezirow's theory by stating more research is required to be undertaken on transformational learning across the span of education. Transformational learning has been explored in the classroom context by Mezirow and others. However, I did not locate any research that considers these ideas in the context of clinical practice. Anecdotally, I have experienced and seen transformation occur in the context of learning in clinical practice and therefore do not support the fourth critique that it is meaningless. This PhD research aimed to contribute to what is known about transformational learning theory within the higher education sector and specifically in the clinical practice context.

My observation is that there is a gap in our current knowledge about transformational learning theory in clinical practice for nursing. For some time now, practice development and active learning have explored transformative learning in the clinical practice setting, however, this has focused on learning from a post-graduate perspective (Dewing 2010) and a curriculum perspective in the final year for students (Middleton 2013). Person-centred learning theory is emerging in the literature and from a curriculum and clinical practice (O'Donnell et al. 2017) perspective, however, this literature is recent and not focused on transformative learning to date. There is no published literature from my understanding, on transformative learning related to students and clinical supervisors learning in the context of practice. Therefore, in line with the critique made by Brookfield (1995) some time ago, there remains a need for further research relating to transformational learning in clinical practice at all levels and roles. However, my attention in the research was to focus on how the crafting of healthful relationships between students and their clinical supervisors influenced transformational learning. I was also interested in the relationship between person-centred and transformational learning. More recently, Tsimane and Downing (2020) in a concept analysis of transformative learning related to nursing education found that there was evidence of transformational learning on the theory-based curriculum. Several models for classroom-based transformative learning were identified with the outcome of the study being a synthesis of these models into a definition and framework to support the development of transformative classroom-based curriculum (Tsimane

and Downing 2020). None of the identified papers were related to practice-based learning or demonstrated a relationship to person-centredness.

Person-centred Practice Framework

In a previous chapter (see Chapter 4), I have explored concepts of person, personhood and person-centredness with a view to how they relate to person-centred care in the context of the McCormack and McCance (2017) Person-centred Practice Framework. In this section of this chapter, I explore the Person-centred Practice Framework with an emphasis on the development of healthful relationships through fostering or creating healthful cultures (McCormack and McCance 2017). There are several approaches to considering humanising healthcare and how these impact on persons for whom we care. I chose the Person-centred Practice Framework as it provided the foundation for person-centredness to be considered outside of the direct patient to caregiver relationship and included the consideration of the care culture (McCormack et al. 2017). This PhD research is focused on the development of a curriculum that supports students and clinical supervisors to craft healthful relationships and how they influence person-centred transformational learning in the context of practice. I believe that the work contributes to emerging knowledge and research in the area of person-centred pre-registration nursing curriculum development (Dickson et al. 2020).

The Person-centred Practice Framework (McCormack and McCance 2017) provides the theoretical scaffolding for person-centred care in the context of healthcare. The Person-centred Nursing Framework was first developed earlier in their first book by Brendan McCormack and Tanya McCance in 2010 (McCormack and McCance 2010) and was further developed in 2017 as the Person-centred Practice Framework. This ongoing redevelopment has challenged the framework to develop in a way that is more inclusive of all persons working in healthcare. This move from a nursing focus on developing therapeutic relationships could be argued to be a shift from the bio-medical approach to healthcare to one where there is a humanised emphasis on the creation of healthful relationships (McCormack and McCance 2017). Healthful cultures are underpinned by healthful relationships and in this context, this refers to shared decision making, mutual respect and trust being essential components of developing

relationships with people we care for and people we work with (McCormack and McCance 2017).

The Person-centred Practice Framework remains a mid-range theory within nursing theories associated with an active programme of international research that is informing the understanding of this as an expanding theory. Person-centredness from this perspective has been explored throughout the United Kingdom and Ireland and internationally in countries such as Australia, Canada, the Netherlands, Switzerland, and New Zealand (McCormack and McCance 2017). Although there are several other definitions of person-centred ways of working, I identified this framework as relevant to the doctoral research as it incorporated a humanistic perspective and considered person-centred learning from a pre-registration curriculum perspective (O'Donnell et al. 2017, McCormack and Dewing 2019; O'Donnell et al. 2020). O'Donnell et al. (2017) argued that person-centredness in the health care environment has been embraced, however, it has not been well operationalised in curriculum development.

To date, person-centred research has focused on the exploration of cultures and recognition that culture change starts with people exploring their individual values and beliefs (Dewing et al. 2017). In relation to this PhD research, having students and clinical supervisors explore how their values and beliefs impact their individual practice formed the initial step in person-centred transformational learning in practice. Considering the pre-requisites, person-centred processes and person-centred outcomes of the framework influenced both the development of healthful cultures and healthful relationships. As discussed in Chapter 3 and earlier in this chapter, the ontological perspective of critical realism, and the focus on values and beliefs arose from Bhaskar's (2008) premise that people have inborn potential (or Dharma) within them, enabling them to determine their path to success (Bharskar and Hartwig 2010; McCormack and McCance 2017).

The Person-centred Practice Framework is intentionally a flat structure that includes the macro contexts, pre-requisites, care environment, person-centred processes and person-centred outcomes. This PhD research focused on the person-centred outcome

of creating a healthful culture that has at the core, the development of healthful relationships (McCormack and McCance 2017). The outer grey ring is the macro-context, including workforce development, which holds significance in the development of pre-registration nursing curriculum. Aspects of the pre-requisites, care environment and person-centred processes (McCormack and McCance 2017) have also influenced and been included within the development of the theoretical framework for my PhD research, Person-centred Transformational Learning in Clinical Practice. I believe a key component to being person-centred is knowing self and this comes with having the courage to practice authentically to our values and beliefs. Brown (2010) believes that we can only be authentic when we have the courage to truly belong. Maya Angelou challenges that belonging can only be realised when you belong nowhere, you realise that you can only belong to yourself, and become free to belong (Angelou and Elliot 1987).

Belonging

In the exploration of belonging, I have learnt that Jack Mezirow's concept of exploring assumptions may look simple, however, remaining forever curious is challenging. From accepting concepts as fact without being conscious of this. I began a journey of understanding belongingness from a person-centred perceptive which led me to consider belongingness from a behavioural sciences perspective through the work of Levett-Jones (Levett-Jones and Lathleen 2007; Levett-Jones et al. 2009; Levett-Jones and Lathlean 2009). In reading a range of articles, I became focused on seeking a definition of belonging related to an assumption that belonging was related to enabling students to fit in. I was initially interested in belongingness as a concept, as it had been explored widely within Australia and internationally as an important aspect of student learning in clinical practice (Hagerty et al. 2013; Levett-Jones et al. 2009).

I undertook a broad, scoping review of the literature on belonging in the context of student learning in the practice context, identifying 18 relevant articles, nine of which included Levett-Jones as an author. Belongingness from a behavioural science perspective, when related to students in nursing practice, has been inferred by Levett-Jones and Lathlean (2009) as a need to belong to a context or environment to optimise

their clinical placement experience. Strategies that assist students to belong have been described as being welcoming, providing orientation to the site and service, greeting the student each day, and the identifying their learning needs and opportunities (Courtney-Pratt et al. 2012; McCoy et al. 2013). In this context, the emphasis of enabling student belonging has been placed on the clinical supervisor and the learning culture of the clinical placement environment. In particular, Levett-Jones and Lathlean (2009) used a mixed methods research approach to develop a psychometric tool demonstrating that the relationship between the student and the clinical supervisor as the most significant factor in determining the students' motivation to learn and their ability to translate theory into practice. From a behavioural research perspective, belongingness in this context identifies elements of the relationship that help students to feel a sense of fitting into their clinical placement. From this perspective, belongingness has rather simplistically been defined as a universal feature of humanness and basic human need (Maslow 1987). It has been further developed by research that is underpinned in a behaviourist perspective as a uniquely personal experience that is contextually mediated in response to the degree to which an individual feels secure, accepted, valued, respected, and connected to a defined group (Hagerty et al. 2013; Levett-Jones et al. 2009).

The similarities and differences of the elements of Person-centredness and belonging have not been explored in the literature to date. More specifically, my interest in the relationship between these two concepts is embedded in the formation and fostering of healthful relationships. Healthful relationships in this context are considered to be underpinned by a focus on understanding self, mutual respect and shared decision making (McCormack and McCance 2017). Relevant to the Person-centred Practice Framework pre-requisites, Borrott et al. (2016) argue that students and clinical supervisors require education to be professionally competent and gain the most from their experience within the practice context. Ó Lúanaigh (2015) suggested that belonging was enabled through the clarity of values and beliefs and knowing self. Moving to the care environment, Levett-Jones and Lathlean (2007), found that effective relationships between students and their supervisors enabled a sense of belonging. However, the care environment also was an inhibitor to belongingness

when students found they were in a practice context that did not align with their values and beliefs (Levett-Jones et al. 2009). Person-centred processes highlighted barriers to belonging for students and this related to their sense of feeling inhibited to be their true selves. The barriers students identified were: feeling rejected and isolated by registered nurses (Honda et al. 2016); perceptions of being discriminated against and ridiculed in practice (Borrott et al. 2016); and feeling overwhelmed and not being able to make effective relationships (Manninen et al. 2013). Person-centred outcomes of a healthful culture were connected to enhanced belonging for students where they experienced effective supervisory relationships, felt appreciated and achieved a sense of flourishing (Levett-Jones et al. 2009; Sedgwick and Kellett 2015).

In applying this to my experience of working with students in an education setting and the context of this doctoral study, belongingness represents a fitting in, placing emphasis on feeling secure, accepted and connected. I believe that fitting in for students encourages them to engage in inauthentic relationships with their clinical supervisor and registered nurses in the clinical practice context that are not aligned to their values and beliefs. Anecdotally, students have expressed to me their anxiety when evaluating their overall placement experience as they fear the consequences of being honest if they highlight any negative aspects. They have expressed a concern that if they are honest about negative experiences, it impacts on them being accepted in the future in clinical settings and may affect them securing graduate positions. This created a curiosity in my thinking and raised my consciousness to what I thought was a reality but was actually an assumption that needed to be unpacked. If this research actively emphasised a focus on belonging, it could encourage students to behave in inauthentic ways, inhibiting their courage to speak up about practice that is not in line with best practice or their own values. From a clinical supervisor perspective, I recognised that they may share an innate desire to seek to fit in I am not suggesting that the innate longing to belong that is described by Maslow (1987) and other behaviourist writings on belonging is not required. Rather I agree this is part of our need to feel secure, belongs within and stems from our instincts from a young age. Related to the nursing profession it is often this need to belong and to care that draws people to the profession.

I met with Professor Tracey Levett-Jones on 3 March 2017 in Sydney, Australia and had a critical conversation on how belongingness and person-centredness are related and the impact of this on developing healthful relationships between students and clinical supervisors in clinical practice. She was interested in exploring how belonging fits with person-centredness and confirmed that this was an area of work that needed to be undertaken. From the review of literature and conversation with Professor Levett-Jones, I developed a new learning perspective that changed my heart and mind on the importance of belongingness and its impact on student learning. I was not sure if I was going to find anything that had not already been discovered in the research that has been conducted to date. On reflection, I was seeing belongingness as fitting into a pre-existing culture where to belong required a moulding of oneself to ensure fit. I recognised that my focus on fitting in and belonging was related to my experiences in life, as a learner and in the workplace. I reflected on my personal yearning to belong and realised it was when I felt that I fitted in, I had the greatest sense of satisfaction in my workplace. I have since realised that my ontological threads and knots as discussed in Chapter 3, explore my struggle to fit in and influenced me to accept a definition of belongingness as fact rather than an assumption that required further exploration. I also realised that there have been times I have sacrificed being authentic in my Being in the workplace to fit in.

The raising of my false consciousness and realisation that I needed to explore further the assumptions I had made about belongingness came to light for me when I began listening to Brene Brown's work on shame and authenticity. As I explored authenticity in her work, I began to consider the perspective of belongingness from the context that we only achieve true belonging, when we belong to ourselves (Brown 2010). Brown's (2010) work in belonging has been largely influenced by Maya Angelou's poetry and self-reflective work where she has written in her book, titled Conversation with Mia Angelou. As part of the conversation within the book, Angelou (Angelou and Elliot 1989, p.22) defines belonging as:

"You only are free when you realize you belong no place — you belong every place — no place at all".

Maya Angelou further added that "the price for this is very high but the reward is

great" (Angelou and Elliot 1989, p.22). In this quotation, she suggested that achieving a sense of belonging to yourself gives you the freedom to be truly yourself. Freedom in this context could be inferred that when "you belong every place," you have the freedom to not feel you need to belong or fit in, rather you have the freedom to belong to yourself and be true to your authentic self (Angelou and Elliot 1989, p.22). Brene Brown (2010) spoke of the shock and dismay she experienced when she first heard the concept that you could belong to no place, rather to every place and in fact to yourself. I related to this, as I also have struggled through my life to feel I belong anywhere and have yearned a level of acceptance from my peers and colleagues, so much so that this created some of the threads and stains on my ontological cloth that I explored in Chapter 3. Significantly, for this PhD research, having the courage to belong to yourself, carries an inherent implication that you do not need to change yourself to fit the mould that others want you to be, rather you are free to be authentic to yourself. This recognises that students and clinical supervisors may need the courage to be authentic. As Maya Angelou stated, this has both rewards and comes with sacrifice as it may be easier to fit in than to be true to your values and stand for what is right. Belonging to yourself from a freedom perspective has a clear link to the Person-centred Practice Framework (McCormack and McCance 2017) in the pre-requisite of knowing self. It is significant that you first need to clarify your values or know self and have the courage to bring your authentic self to the health care context through authentic engagement. Having the courage to speak the truth may result in enacting change rather than conform to a culture that does not sit within your values and beliefs (McCormack & McCance 2017). However, not fitting in may also have consequences as being authentic can isolate a person from the collective and requires courage to stand up for what is right even if this is not popular. Belonging from a freedom perspective is a thread that runs through this thesis, as I hold the assumption that it is an important element in crafting healthful relationships.

The revised assumptions I then took to the PhD research were that all persons were responsible for the authenticity they bring to their nursing practice. This also requires the concept of belonging to be embraced by facilitators of learning and embedded into a contemporary curriculum. Imperative to this is the exploration of values and beliefs,

and how as individuals we relate this to the Registered Nurse (RN) Standards for Practice (NMBA 2016). I would advocate it is when students are able to achieve this that they are enabled to be empowered to be transformational nurses of the future. Having the courage to belong to themselves should enable them to not feel they need to fit in rather that they can develop Doing and Being in practice in a way that is true to their own personhood and not meld to what they believe others expect of them. I remain very respectful to the research and knowledge shared within the literature of belongingness from both the behaviourist and social science perspectives. However, I believe that by encouraging belonging to fit in we are limiting a person's potential for transformational learning and their ability to achieve Becoming or gain new learning perspectives (Mezirow 2000) and a sense of human flourishing (McCormack and McCance 2017) in clinical practice. I believe belongingness is best achieved within a healthful relationship between students and clinical supervisors. I propose it is belonging from a freedom perspective that underpins person-centred transformational learning.

The Development of a Theory of Person-centred Transformational Learning

I began to consider the theoretical underpinnings of my PhD research by exploring different philosophers' writing and considering their perspectives on how they understand the world to be. I came from an ontological understanding where I had considered my own values and beliefs from the perspective of how I viewed the world as a result of my life experiences and the paradigm of critical realism. Critical realists are led by ontology; however, they appreciate each ontology's uniqueness and complexity and look below it to discover what exists beneath the surface (Mingers 2014; Wilson and McCormack 2006). To assist clarity of the theoretical assumptions, I undertook a creative process of drawing my understanding of how Habermas (1987), Mezirow (2009) and Fay (1987) fitted together with my research question. This drawing as shown in Image 6-4, demonstrated my initial thoughts of their influence on creating healthful relationships and transformational learning. The drawing was a conduit for me to commence critical dialogue with my supervisors and critical friends. In crafting this image (see Image 6-4 below), I felt overwhelmed by the information I had read but used this imagery to portray my philosophical assumptions.

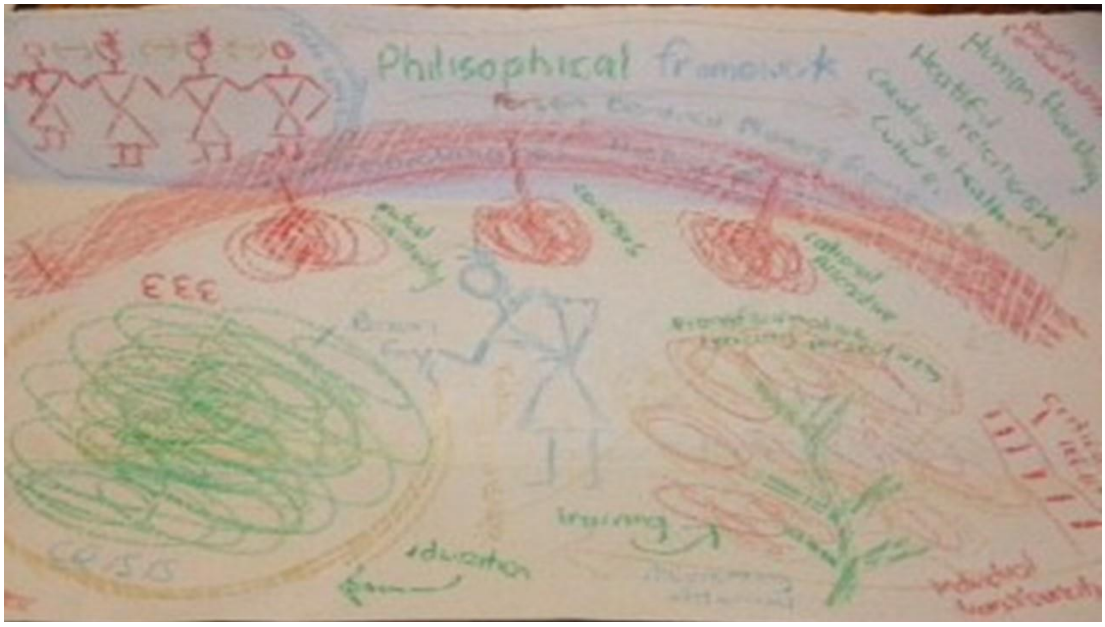


Image 6-4 Stage 1 Conceptual Framework Creative Process (2017)

There are many aspects included within this drawing (see Image 6-4) and, on reflection, I made it more confusing by trying to include every detail. I had read about critical theory and transformational learning. A significant point of clarification for me was when I was able to present this picture to a group of critical friends (Hardiman and Dewing 2019) who provided person-centred feedback. They challenged me to consider why I needed to include all three philosophers and decipher the gems from these theories that I wanted to consider to inform my research and make sense of the data I collected. The challenge presented to me reaffirmed that I was comfortable with including more than one philosopher, however, I also realised that the complexity in this drawing needed to be refined.

Following my reconsideration of the theoretical perspectives, I again undertook another creative painting process to refine my thinking. This resulted in the painting below (see Image 6-5).

Image 6-5 Stage 2 Conceptual Framework Creative Process (2017)

The reflective process that resulted in the creation of the painting above (see Image 6-5) shows I have kept the three philosophers; however, I clarified the gems from within their writings that were relevant to my research. I initially thought this would assist in my overall understanding of the philosophical underpinning. However, I ended up with many more ideas that were added to the final development of the theoretical framework. In the painting above, the blue arch with the three colours represented Habermas's (1987) elements of his Communicative Action Theory that are relevant to this research, power, rationality and critical dialogue. In addition to this, the Habermasian (Habermas1987) concept of safe spaces was represented in the sun, important to creating the prerequisites of an intentional facilitative relationship (Hardiman and Dewing 2019). The tree demonstrated how Mezirow (2009) provided students and clinical supervisors with critical reflection and critical dialogue tools. They use these tools to move from their disorienting dilemma from the black to the red swirl where they flourish to be the transformed learner in the form they chose to be (represented in the small tree on the right-hand side of the drawing) not the one that is bestowed upon them. Disorienting dilemmas or periods of crisis occur in practice due to the practice context's complexity (Mezirow 2000). The person soaring in Image 6-5 represents a student or a clinical supervisor who experiences transformation and flourishes where their initial meaning scheme or understanding is transformed to a new

more informed learning perspective (Mezirow 2000). After critiquing Fay's (1987) theory of crisis, I decided to no longer include this theory as it did not provide the student, who is in crisis, with any ladder or support, to emerge from their place of dwelling. Rather, it was dependent on time to allow the person to emerge with a sense of enlightenment, empowerment and emancipation. For this PhD research, students and clinical supervisors were in clinical practice for a period of two weeks and therefore they did not have the time to dwell; rather, they need a ladder that assists and supports them to transform their learning.

Moving from philosophical principles to a theoretical framework

To move the philosophical underpinnings of Image 6-5 to a theoretical framework, I again undertook a creative process (see Image 6-6). I was challenged by my supervisory team to turn the artwork into a framework that was able to be shared with others. I achieved this by going to a local beach with a critical friend (Hardiman and Dewing 2019) and using the sand, other materials and the natural environment to assist me to blend and meld my creative work, critical conversations, reflections and emotions into a representation of a theoretical framework. I began by considering the application of the above philosophical underpinnings immersed within my research question. I was feeling very uncomfortable for two reasons. Firstly I was unsure of where to begin and what the outcome would be. I was worried if it would it be enough and I had a sense that something was missing from the initial image above (see Image 6-5) however, I was unsure what this was.

Image 6-6 Beach Creation Theoretical Framework (2017)

As I began to collect items and consider what I would create on the beach, my critical friend held space for me and provided support and encouragement. She sensed my discomfort; however, we did not discuss this until the process was complete. At this point, I was prepared to walk away as my discomfort was intense, but her patience and gentle persuasion enabled me to complete the creative activity. I began to create circles that interconnected (see Image 6-6). These circles were named Knowing, Doing, Being and Becoming. They were then filled with items that helped me to explain their purpose and connectivity. I intuitionally placed an outer circle surrounding the interconnected circles that represented the care environment, students and clinical supervisors. Following a critical conversation, I placed a second circle that represented the macro context. I was intrigued by the concept of holding space or companioning a person when they have discomfort with a learning activity or process. After exploring the literature, I had not previously considered this and realised there is a silence in how this enables transformational or person-centred learning. This concept of holding space has formed part of the exploration within this PhD research. I feel it provided an opportunity for my transformational learning to achieve something I did not believe I was capable of achieving.

My greatest insight and learning regarding the theoretical framework from this process was the absence of the Person-centred Practice Framework (McCormack and McCance 2017) in the previous considerations of the philosophical underpinnings. It became obvious through the process that this was the element that I had sensed was missing at the onset of the creative representation on the beach. The Person-centred Practice Framework provided key elements within the theoretical framework to enable the students and clinical supervisors to navigate the unknown beneath the sea in (see Image 6-6) and make their way to the island, which represented the transformed learner who has gained a new learning perspective.

The next part of the theoretical framework development was the transformation of creativity to reality in the form of a diagram that represented the application of transformational learning in practice through the development of healthful relationships.

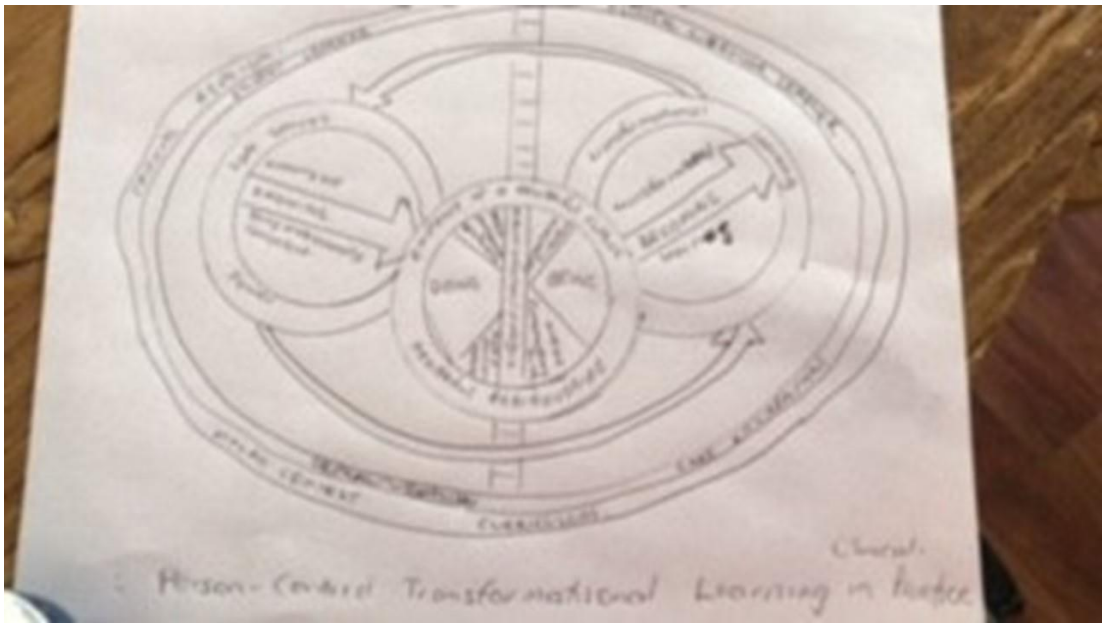


Image 6-7 Paper Draft of the Theoretical Framework - Person-centred Transformational Learning in Clinical Practice (2017)

This image above (see Image 6-7) represented the beginning of drawing a theoretical framework for student and clinical supervisor learning that conceptualised, distinguished, and organised the theoretical underpinnings of this PhD research. It

enabled the application, organisation and positioning of this in a wider field of research, fundamentally critical theory (Habermas 1987), person-centred philosophy (McCormack and McCance 2017) and transformational learning theory (Mezirow 2000). I named the theoretical framework, Person-centred Transformational Learning Theory in Clinical Practice. This name provided an overview of the purpose of the framework, relating it directly to the PhD research question: How do healthful relationships between students and clinical supervisors influence transformational learning?

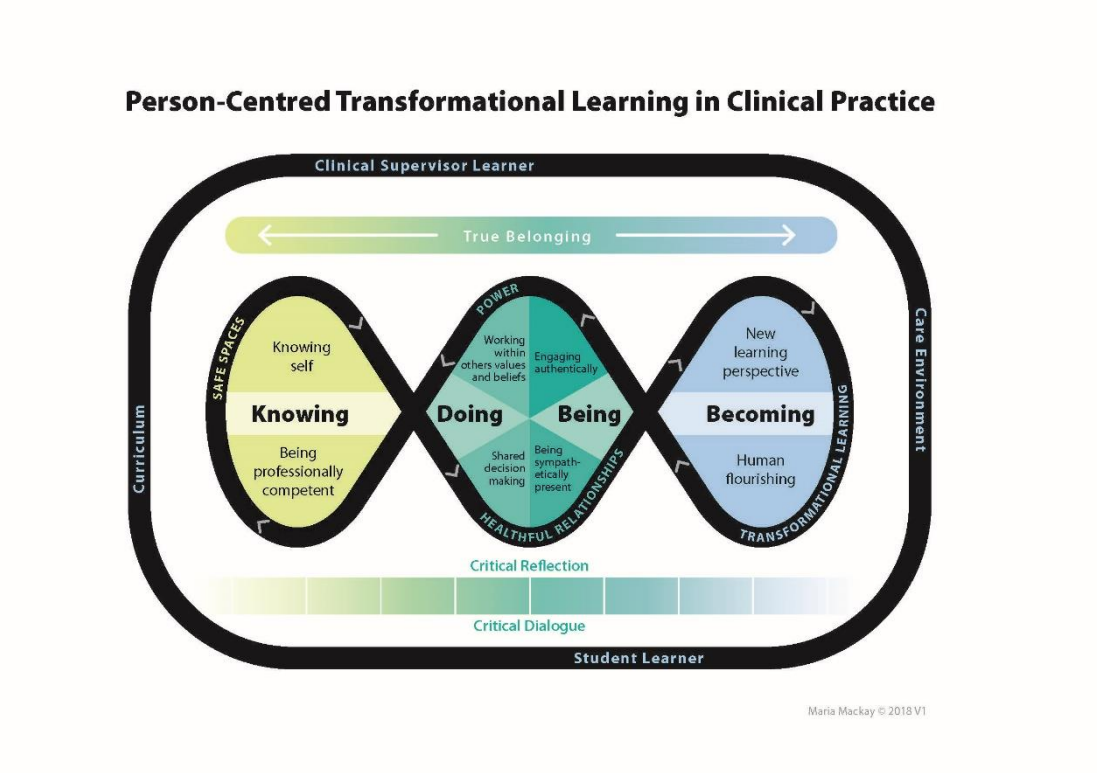


Image 6-8 Draft 1 - Theoretical Framework - Person-centred Transformational Learning in Clinical Practice (2017)

The framework above (see Image 6-8) was the initial draft of the theoretical framework that both informed and was utilised within the research. This model took the drawing from the image (see Image 6-7), presenting it as a more formal theoretical framework. I have positioned this as a theoretical framework as it summarises the three theories that have been developed and that informed my PhD research (Kivunj and Kuyini 2017).

The theoretical framework for ‘Person-centred Transformational Learning in Clinical Practice’ was designed to be purposely a flat structure that does not have implicit within it a hierarchical structure, as the learning that occurs is significant for both the student and clinical supervisor. The outermost, overarching circle has the student and clinical supervisor as surrounding the conceptual framework, as equal partners (Habermas 1987). The other element within this circle is the care environment. The care environment is complex, changing and must be respected and appreciated to ensure that the idiosyncrasy of each individual environment is considered. Curriculum is also within the outer circle and included to demonstrate the influence this has on how both students and clinical supervisors experience clinical practice. Within this all of the elements within the person-centred nursing framework were relevant: appropriate skills mix; shared decision-making systems, effective staff relationships, power sharing, the physical environment, supportive organisational systems, potential for innovation and risk taking (McCormack and McCance 2017). The outer circle represented the curriculum and the concept of developing person-centred curriculum in the pre-registration space, as a contribution of this PhD that specifically aims to illuminate person-centred transformational learning in the non-classroom setting. True belonging is represented in the image below (see Image 6-10) as an element that runs across all aspects of person-centred transformational learning. In this context, true belonging is the ability to belong in a way that is true to one's values and beliefs. The framework has been dynamically created throughout this research with the final version represented in Chapter 10; this framework was updated, and true belonging was changed to healthful relationships as belonging was found to be fundamental to a healthful relationship; however, this has been demonstrated in Chapter 10 to be from a freedom perspective (Angelou and Elliot 1989). Healthful relationships then moved to the top to demonstrate that enabling both students and clinical supervisors belong to themselves and their values and beliefs, is a key element of human flourishing and authentic practice.

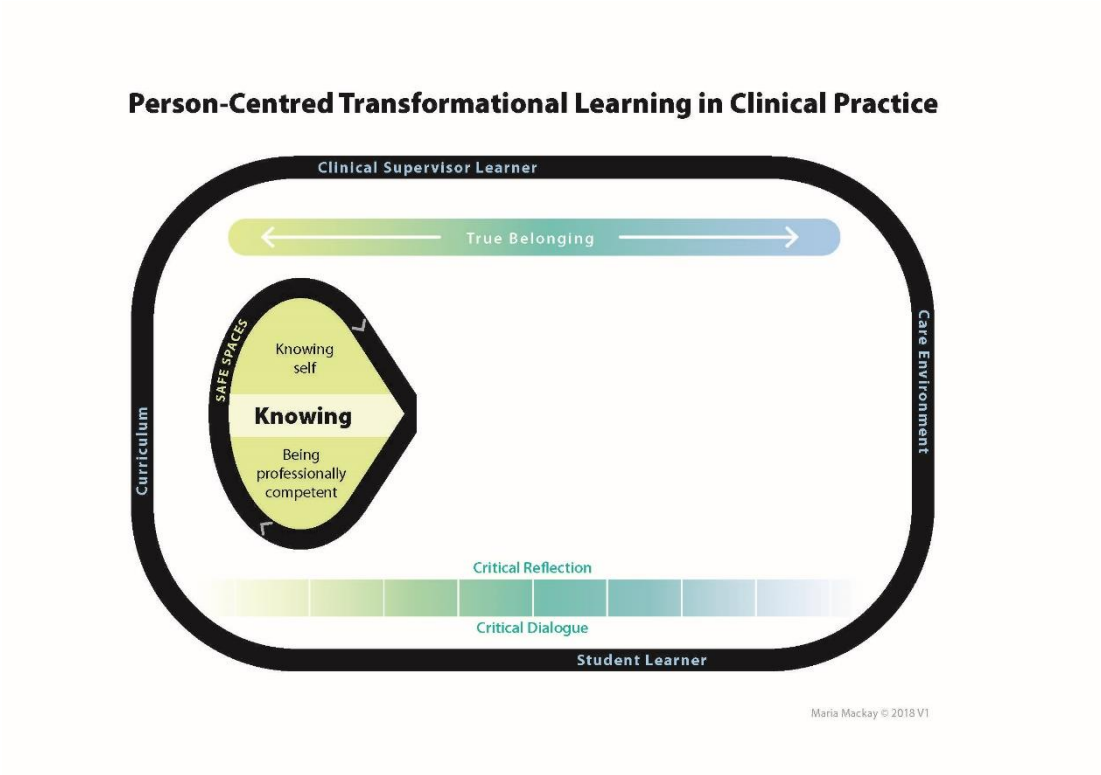


Image 6-9 Draft 1 - Knowing in the Theoretical Framework - Person-centred Transformational Learning in Clinical Practice (2017)

The inner cycles from the left start with Knowing (see Image 6-9). It is the stage that Mezirow (2009) would describe as the meaning scheme, the stage where you take your current learning perspective into practice, from which you initially view the care environment. It begins with the Habermasian (1987) elements of the creation of a safe space and consideration of power. Roderick (1986) argues that from Habermas' writings, power must be considered and respected if it is to be addressed and equalised. Knowing as a process has the elements of the Person-centred Practice Framework from the pre-requisites (McCormack and McCance 2017): knowing self and being professionally competent. The Knowing phase in the context of this PhD research was a ten-week academic session which formed the students' theoretical and practical preparation; and the eight -hour workshop for clinical supervisors. These pre-requisites were included as they provided the basis for practicing within a person's own values and beliefs, ensuring both the students and clinical supervisors were prepared for the skills required within each allocated placement period. The Knowing phase began prior to the placement period commencing, however, it could be revisited as part of the placement if several iterations of the cycle occurred within one placement period.

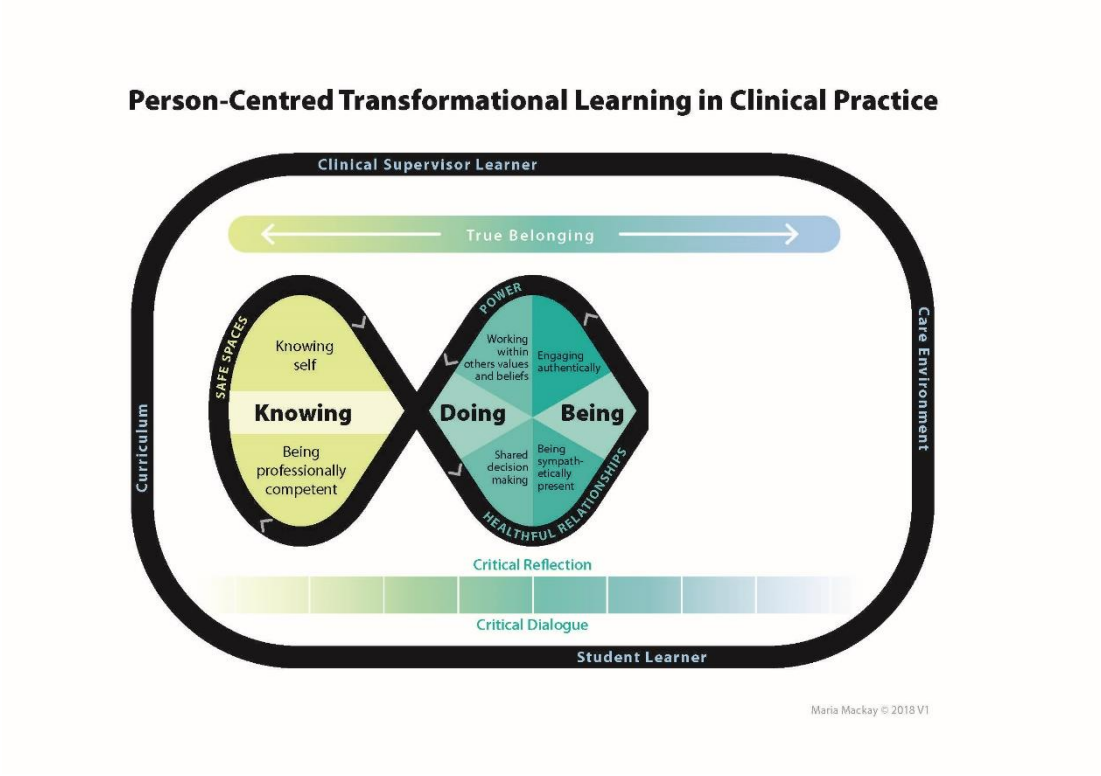


Image 6-10 Draft 1 - Doing and Being in the Theoretical Framework - Person-centred Transformational Learning in Clinical Practice (2017)

Moving to the Doing and Being circles, the person-centred outcome of the existence of healthful cultures surrounded this process underpinned by the development of healthful relationships (see Image 6-10). This was not meant to suggest that they must exist, rather highlight the need to examine if they are present at the onset of the clinical placement or develop due to the influences or events that unfold during the placement period (McCormack and McCance 2017). Doing is the more technical side of the diagram and focused on the person-centred processes of working with beliefs, values, and shared decision-making. The term 'patient' has been purposely removed, as in this context a holistic approach to values and beliefs included all persons involved within the healthful relationship. Being formed the beginning signs of the transformed student or clinical supervisor as it is through Being that people are encouraged to hold space for each other to become, flourish to their own full potential, or be the nurse they choose to be. This involved the person-centred processes of being sympathetically present and engaging authentically (McCormack and McCance 2017).

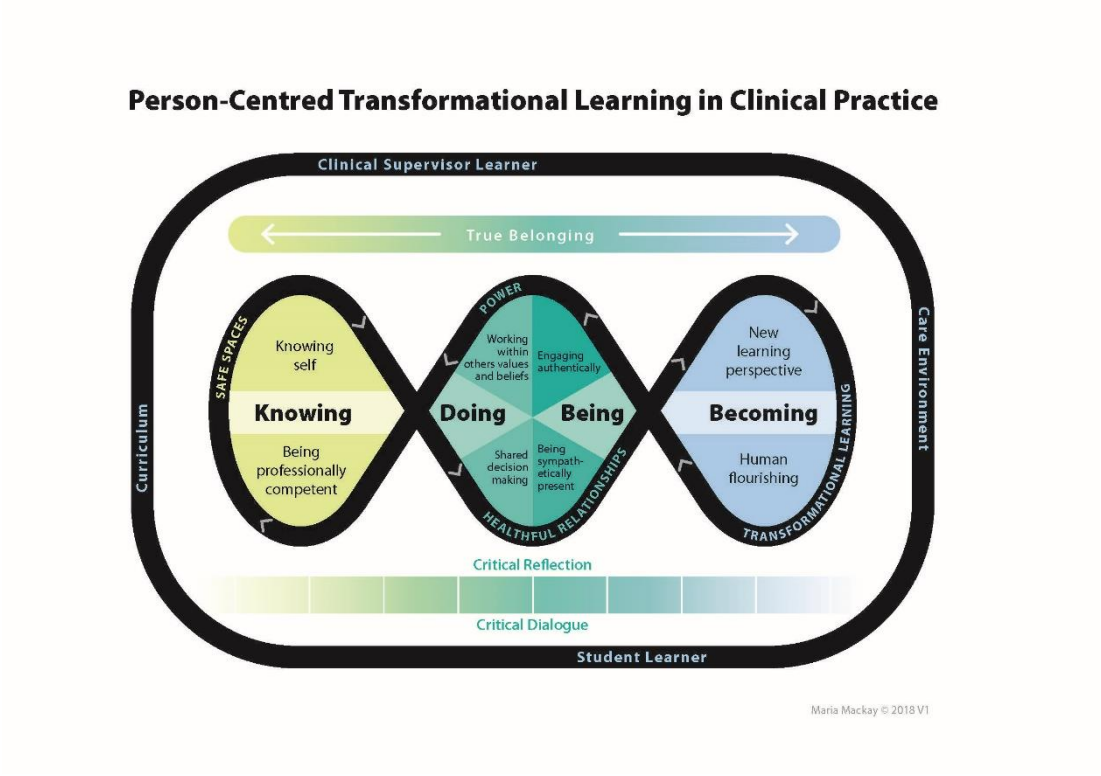


Image 6-11 Draft 1 Theoretical Framework - Person-centred Transformational Learning in Clinical Practice (2017)

The final circle is Becoming (see Image 6-11), where students and clinical supervisors, through their experience in clinical practice, developed a new learning perspective that enabled them to flourish to their full potential. Significantly in this phase, the growth that occurred is determined by the learner. In the case of the student, they determine their growth and received feedback as to whether this growth is sufficient and ultimately enough to be successful. The feedback provided should respect the person receiving the feedback. Clinical supervisors should refrain from placing their values and beliefs onto the student. Becoming is also a consideration for clinical supervisors where they need to remain open to learning from clinical practice and the students they are in practice with. Surrounding Becoming is Mezirow's (2009) theory of transformational learning, something that may occur during a clinical placement period or sometime after the actual placement and as a result of students or clinical supervisors continuing to be involved in further critical reflection and critical dialogue. The arrows that connect the first and last circles show the iterative process that is involved in transformational learning in clinical practice. This again can be relevant to

several iterations in the one placement period, or it may be a connection of one placement period within a given academic session to the next placement period.

The ladder in the framework underpins the circles (see Image 6-11) and accommodates Mezirow's (2009) interpretation of critical reflection and critical dialogue. The combination of both provides the tools for students and clinical supervisors (outer circle) to reflect on and grow within the disorienting dilemmas they face. It is a significant component of the conceptual framework and is what enables a learner to move through Doing and Being to Becoming in clinical practice.

The draft 1 framework (see Image 6-11) is the one that was utilised as a part of the PhD research. Chapter 10 provides an overview of the synthesis and meta-synthesis and represents the framework with minor changes as a result of the discoveries made from the information collected within this PhD.

Testing of the initial draft Framework

From November to December 2017, I was very fortunate to accompany eleven students to Cambodia for a voluntary clinical placement as a clinical supervisor for a period of twenty-three days. This opportunity gave me time to reflect on the application of the framework from my perspective, the perspective of another clinical supervisor and two students. This experience was opportunistic; however, one which I feel provided me with an insight into the application of the developed theoretical framework. I shared my learnings from this as a reflection using the Mezirow (2009) model of reflection.

My initial assumption was that the framework may have too much theory and be too busy with a lot of elements that may confuse the learners. In the review of the framework by both the clinical supervisor and the students, they were able to interpret the key elements of the framework and to identify that this was an iterative process. A student described the outer circles as less clear as she was not familiar with the terminology, and this was reiterated by the clinical supervisor. The parts of the Person-centred Practice Framework within the Knowing phase of the model were clear to both. Most importantly, within the Knowing circle, the significance of knowing self and

considering what you are taking into a new clinical placement was understood. I had made the assumption that Carpers (1978) Ways of Knowing was intrinsic within the Knowing phase however this was not the case, although I believe intrinsic person-centred learning should be all forms of intelligence and ways of knowing. Given that Ways of Knowing is focused on learning and reinforced on several occasions within the Bachelor of Nursing Program at the UOW, Australia, I felt it was reasonable to make this assumption. We had an interesting conversation about power, the students shared that currently, they have a perception that they are paying for a service and see themselves as customers, so they do not necessarily believe that there is a power imbalance; I found this remarkably and a key learning for me as an academic and researcher. The concept of students' perception of power was also similar in the PhD research and is discussed later in chapter 8.

Within the next circle, Doing was clearer than the Being circle to both the student and supervisor. I have an assumption that Doing is clearer than Being as this is what both clinical supervisor and students focus on during the placement period. This was reinforced through the overall placement experience from a student perspective. From my perspective, we took eleven very shy, introverted students away and although they were very good at the technical aspect of point of care nursing, they were challenged in the non-technical skills of interpersonal communication and when considering practice at an emotional and cognitive level. This challenged me to a point of disorientating dilemma, as I believed the students did not gain from their experience what they could have due to their introverted nature. I challenged myself to be true to my philosophical underpinning and enable this group to flourish to a point where they believed they had grown. I had to reconsider my espoused values and beliefs and the philosophical underpinnings of this PhD research, where I believe students have the right to determine their own personhood. I had to check in with myself and the other clinical supervisor as we were starting to place our own values and beliefs upon this student group. A teachable moment for me was when I allowed myself to be annoyed with a student and demonstrate my frustration in my behaviour towards her. I consequently moved back to Knowing at this point from Doing and revisited my values and beliefs. The confusion with the Being side needs to be more explored and mutually

agreed to ensure there can be a shared vision of how we can facilitate learning for each other by engaging authentically and being sympathetically present (McCormack and McCance 2017).

The students and clinical supervisor reported that Becoming as a concept was clear. I had begun with the assumption that students would undertake a cycle for each placement period. The application of the framework has shown me that this is the case for some students and clinical supervisors, however for others, they repeat the cycle multiple times in one placement period. Neither is right or wrong. The process should be individualised and able to meet the needs of each individual.

A quote from a student was that "Being is enough, we should be patient and wait for Becoming to reach us." I found this quote to be profound and a teachable moment for me. I reflected back on this during my time away and I continue to be challenged by it. Is it enough to be or should we always strive for Becoming? I believe we need to strive to become however in achieving that we can sit in the Being space for some time and either hold that space ourselves or have a critical friend hold the space with us. Becoming occurs when the time is right.

I have reflected on the difference between facilitating the learning of others and me placing my values and beliefs on students as a result of the experience I had with this group. I found at point of care this group of students to be technically sound, their issues were in their application of person-centred ways of being in their non-technical or communication skills and their cognitive skills. In our assessment process, we would have had three students graded below the (required) shaded area and awarded a fail grade if this was a summative placement. The students did receive this as critical feedback and as this was a voluntary experience, it did not count towards the award of their degree. I am mindful these students may have flourished in a way they are comfortable with. I remain challenged with the separation of improvement to the decision of a student being awarded a pass or fail grade whilst maintaining a sense of hope, using language that is future-focused and believing the problem is temporary. I provided authentic person-centred feedback with the students as it was important to be

kind while also role modelling working within my sense of values and beliefs. The outcome I believe for this group of students was that those who moved to Becoming did that within their own time and space, realising their full potential through undertaking critical reflection and critical dialogue with their families and critical friends back home.

Chapter Summary

From the synthesis of the ontological and epistemological discussion that formed the initial part of this chapter (see title - philosophical and theoretical influences), I have developed the following epistemological principles. Philosophically (in no particular order), I believe:

Principle 1 (Bhaskar 2008)

- That persons have the genius (Dharma) within them to flourish to their full potential.

Principle 2 (McCormack and McCance 2017)

- That persons who have the courage to know themselves through the exploration of their values and beliefs create the potential for human flourishing.

Principle 3 (Habermas 1987; McCormack and McCance 2017; Mezirow 2000;)

- The creation of safe spaces enables person-centred transformational learning to occur.

Principle 4 (McCormack and McCance 2017; Mezirow 2000)

- Crafting healthful relationships enables learners to move through Knowing, Doing, Being and Becoming.

Principle 5 (Mezirow 2000)

- Becoming is a life-long journey that creates new lenses that were once unknown to us.

Principle 6 (Mezirow 2000)

- Critical reflection and critical dialogue are the ladders for transformational learning when learners are faced with disorientating dilemmas.

I believe this chapter has presented the development of a theoretical framework that provided clarity in developing person-centred transformative learning in clinical practice. I have argued that the positioning of transformational learning with person-centredness is a not a new concept however does add to current knowledge as little is known about how to facilitate person-centred transformational learning in the context of practice. My aim through this PhD research was to further explore the influence of healthful relationships on transformational learning, with the potential to inform educational practice in the future.

To summarise, the above exploration of epistemology provides the foundation for understanding information in this PhD research. The following poem helps to synthesise my learnings from this chapter:

Poem
Critical realism helps me make sense of the world
Creating shared values are the foundation
Creating safe spaces enables sharing and growth
Disorientating dilemmas provide the gateway to learning
One perspective turns into another perspective
New learning perspectives are the key to Becoming
Disorientating dilemmas contribute to developing healthful relationships
Belonging unlocks the pathway from Knowing to Doing and Being and Becoming
Enabled, empowered and transformed
Person-centred transformational learning in clinical practice
Creating nurses who practice true to their values

Moving to Chapter 7, the chapters to this point inform the methodology that was used in undertaking the PhD research. The theoretical framework developed in this chapter represents how the research will be understood, where the methodology moves the concept of person-centredness into how the research will be conducted.

Chapter 7

Exploring Person-Centred Methodology

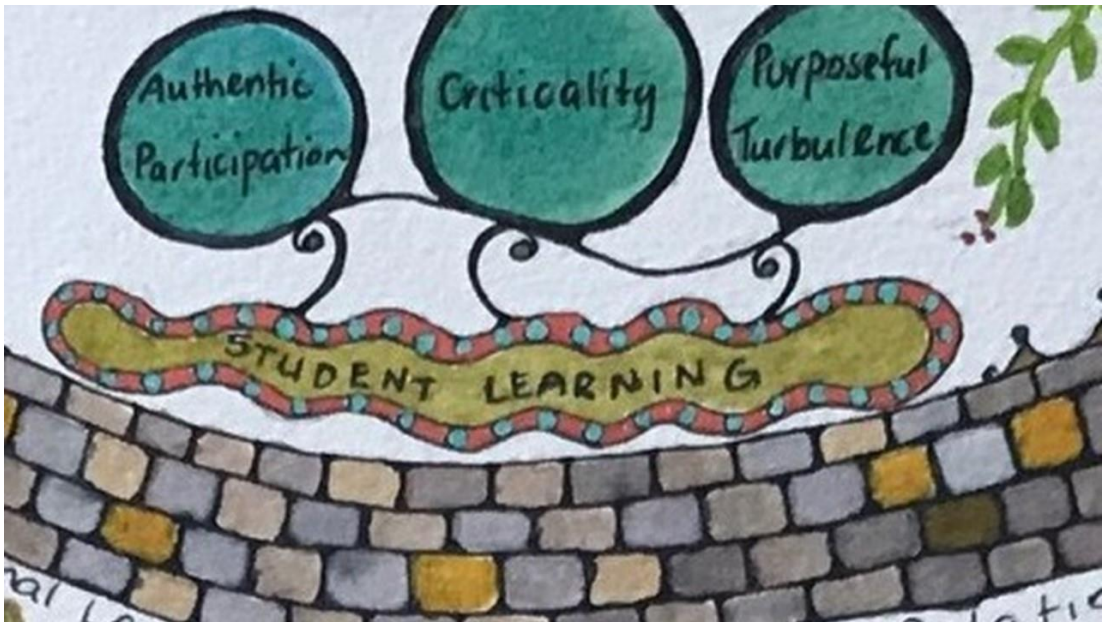


Image 7-1 Exploring Person-centred Methodology (2020) - © Maria Mackay 2020

Introduction

In this chapter, I present the methodological framework that underpinned my PhD research. The framework outlines the significant elements that created a participatory and person-centred approach to exploring my research questions (see Image 7-1 above). My PhD research was informed by the ontological, personhood and theoretical principles that have been discussed in the previous chapters of this thesis. This chapter begins with exploring the ontological and epistemological influences that have informed the development of the 'Participatory Person-centred Framework for Exploring Healthful Relationships in Clinical Practice'. It then provides an insight into Dadirri, an Australian Aboriginal term that refers to 'inner deep listening and quiet still awareness' (Ungunmerr 1988). My methodological framework elements are entwined within the Dadirri poem to demonstrate how deep listening and quiet still awareness influenced the methodological approach to the research process within this PhD research. Finally, the methodological principles that informed the approach to this PhD research will be outlined.

Background

Cohen et al. (2018, p.53), argued that several paradigms are relevant for educational research however a critical educational research approach seeks to question and transform both educational processes and society. They further purport that consideration of the ontological and epistemological assumptions leads to methodological characteristics that have the intent of transformation, equalisation of power, changing society and encouraging democracy. In this PhD research, the methodological approach utilised will be interwoven within the ontological perspective of critical realism and my perspective of personhood where there is a belief that people have within them what they need to flourish to their full potential (Bhaskar and Hartwig 2010). Aligning the epistemological perspective critical theory, specifically the Habermasian influence of communicative theory (Habermas 1987) within the methodical principles, places a particular emphasis on power and rational discourse when considering participation from an emancipatory participatory approach.

My PhD research drew on several necessary and complementary theoretical underpinnings in participatory person-centred research methodology. Methodology is defined by Cohen et al. (2018, p. 53) as

> …how we research complex, multiple realities: influenced by communities of practice which define what counts as acceptable ways of researching, and which mixed methods can feature, as they enable qualitative dialogue to be established between the participants in the research.

The above definition, derived from an educational perspective, has a broader application from a critical realist ontological perspective where multiple realities are an accepted truth (Bhaskar and Hartwig 2010). As part of my ontological perspective explored in Chapter 3, there is an acknowledgement that multiple realities need to be considered and contextualised as part of the research process. The emphasis in the above definition on complexity is pertinent as complexity in both the educational and healthcare environments intensifies with the collision of theory and practice in the reality of clinical practice. This PhD research is embedded in education and curriculum

research and utilised the concepts of critical dialogue and reflection as a conduit to enable transformational learning for both students and clinical supervisors.

There are many approaches to understanding what is known and unknown and with all paradigms having their own relevance, it is up to the researcher to argue for the approach they take and how it will best address the PhD research in question (Fay 1987). Historically, research approaches have been largely positivist (or quantitative) or interpretivist (or qualitative) in nature. In healthcare and education, both these approaches have been accepted as effective ways to undertake research. Reid (2012) argues that in medical research the positivist approach of randomised control trials has long been accepted as the gold standard for eliciting evidence for medical interventions while allied health professionals, in exploring relationships have driven interpretivist research. McCormack et al. (2017, p. 12) contest this and argue that by challenging this traditional approach to healthcare and having an "eclectic knowledge base", researchers can contextualise knowledge to the person. It is argued that, in traditional research approaches, the person is missing and just as in the implementation of person-centred practice, we need to have the courage to utilise person-centred approaches to "enrich and define our research practice" (Reid 2012, p. 337, McCormack et al. 2017).

A person-centred approach to research methodology is considered to be non-traditional and more relational, value laden with the ability to "bring life" to the philosophical and theoretical underpinnings of this PhD research (McNiff and Whitehead 2011, Reid 2012, McCormack et al. 2017, p. 14). Working from these principles, a person-centred approach to research will be utilised within the methodological approach to this PhD research.

Participatory approaches to research lie within the action research evidence base (Kemmis et al. 2013). Participation as a concept has significant variations in its application, however, all levels of participation have an element of participant action within them. Bergold and Thomas (2012, pp. 195-200) describe the fundamental principles of participatory research as 'democracy' as a precondition for participatory research, the need for safe spaces, who participates, how the community is defined and

differing degrees of participation. These principles are further explored below with consideration of their relevance for this PhD research.

Democracy as a Precondition for Participatory Research

The relationship between an individual's voice and the reaching of consensus is an important issue to explore in democracy. If the aim is for persons involved within the research to belong (Angelou and Elliot 1989; Brown 2010) to themselves, it is important that their voice is heard and respected. However, at salient points in the research process, the voices of individuals need to reach consensus. Habermas (1987) contends this occurs through rationality and mutual consensus. Dialogue and critical discussion are required to reach this consensus and Habermas (1987) would argue this is where the individual voice and the exploration of rational alternatives provide the environment for mutual consensus to be achieved. Inherent within this methodology is the belief that the environment empowers participants to be active in the design and implementation of research studies. It empowers participants "to construct and use their own knowledge" (Coghlan & Brannick 2014, p. 55). To minimise the effect of perceived power and to enable and empower all participants to have an active and equal voice, participants were invited to be involved as co-researchers from the beginning of this PhD research (Snoeren et al. 2012).

Piper and Lazar (2018) argue that participatory and co-design approaches to research, empower participants and lead toward democratisation. Co-design especially enables a hands-on experience and values the participants' lived experiences. They further contend that the participatory intent of the research enables the participants and co-researchers to discover outcomes that bring about true practice change rather than meeting the outcomes required by the expert researcher. In conclusion, the outcome from co-design research results in advocacy and societal change as much as it is in meeting the research aims and answering the research question.

The need for safe spaces

This PhD research will utilise the creation of safe spaces as communicative spaces for participants and co-researchers to have a space for authentic participation. Habermas

(1987) describes the creation of communicative spaces as an essential element of undistorted communication. Bergold and Thomas (2012, p.197) explored this concept further and suggested that "spaces need to create a conducive environment for openness, the difference of opinions and conflict." For this PhD research, the creation of safe spaces considered each of the groups' individual needs separately, recognising that what is considered safe for students may differ from what is perceived as safe for clinical supervisors. Having environments that allow for openness and conflict to be accepted forms of communication will evolve over time and will require the group to remain mindful to continually checking.

Who participates – how is the community defined?

Defining the community of participants is essential for research and I draw on Habermas and Le Dantec and DiSalvo for their work on public. Habermas (1987) describes the concept of public spheres as groups of people within a common society. Le Dantec and DiSalvo (2018) utilise the concept of the public from the work of Dewey where he argues that a public is a group that is bound together either directly or indirectly for good or evil. Further, they define a public as a group of co-researchers who are bound together by a common cause or a common confronting issue. The concept of a public can also be a larger group that can divide into more specific and smaller groups.

Therefore, applying this concept to this PhD research, the larger group was all persons involved in a student's clinical placement, including students, clinical supervisors, and academic staff. Each of the two groups formed their own discrete group with the support of the academic staff or the chief investigator researcher. The two groups were students and clinical supervisors, each group was independent of the other.

Differing degrees of participation

Authentic participation is congruent with people making an informed decision as to the level of their participation and having the opportunity to revisit and change their level of participation at any point within the research process (McCormack and McCance 2017) with co-researchers seen as important within participatory and person-

centred research methodology (McCormack et al. 2017). Each of the participants (students and clinical supervisors) regardless of the group they belong to were given the choice of being participants only or a participant and co-researcher in this PhD research.

Methodological Framework

The **Error! Reference source not found.**) below, titled 'Participatory Person-centred Methodology for Exploring Healthful Relationships in Clinical Practice', represents the key methodological concepts essential for this PhD research. It is influenced by the theoretical framework Person-Centred Transformational Learning in Clinical Practice' (see **Error! Reference source not found.**). My methodological framework blends and melds the concepts of authentic participatory, person-centred and action-orientated approaches to portray how the principal researcher along with the co-researchers will engage with participants, collect information, understand the information collectively, reflect on the implications for current and developed shared ways of working for future practice. The methodological framework is influenced by the theoretical framework 'Person-Centred Transformational Learning in Clinical Practice' in that the concept of developing healthful relationships informs both the epistemological and methodological approaches to my PhD research. The theoretical framework outlines the foundations for the research and the lens through which the research will be interpreted. The methodological framework enabled me to unpack how deep listening and quiet still awareness (Ungunmerr 1988) informed the research process. Below are the frameworks (see Image 7-2 and Image 7-3) that capture the key principles and were developed specifically for this PhD research.

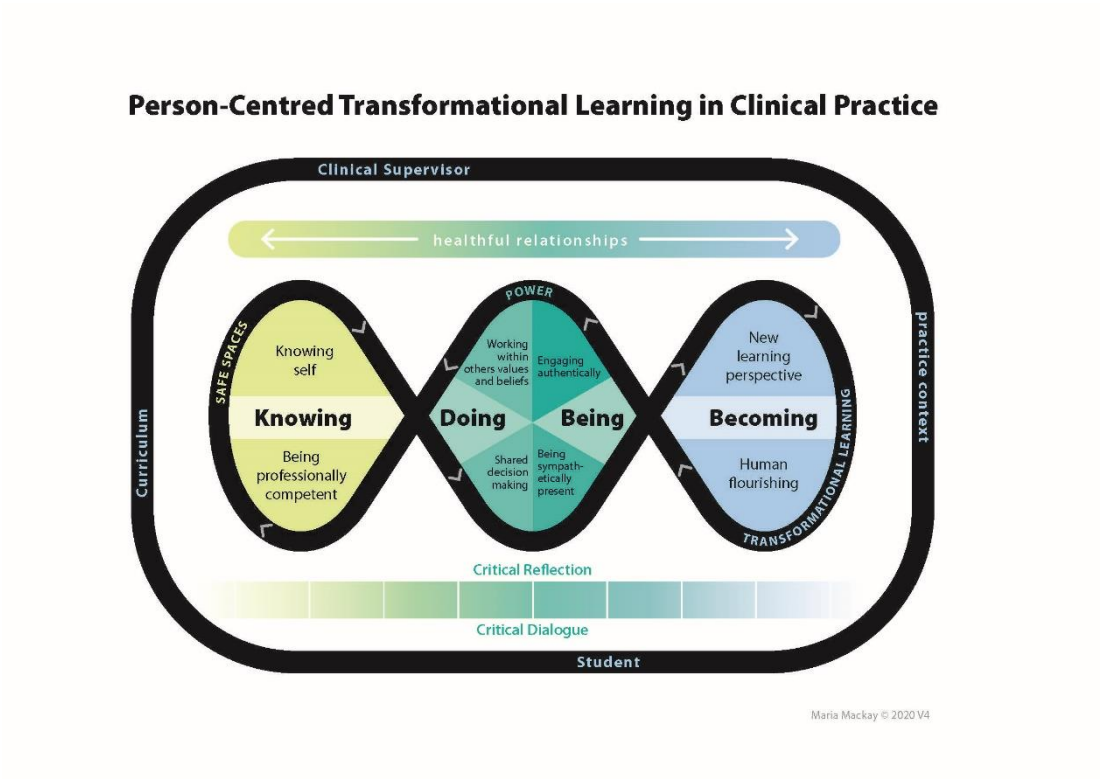


Image 7-2 Person-centred Transformational Learning in Clinical Practice (2020)

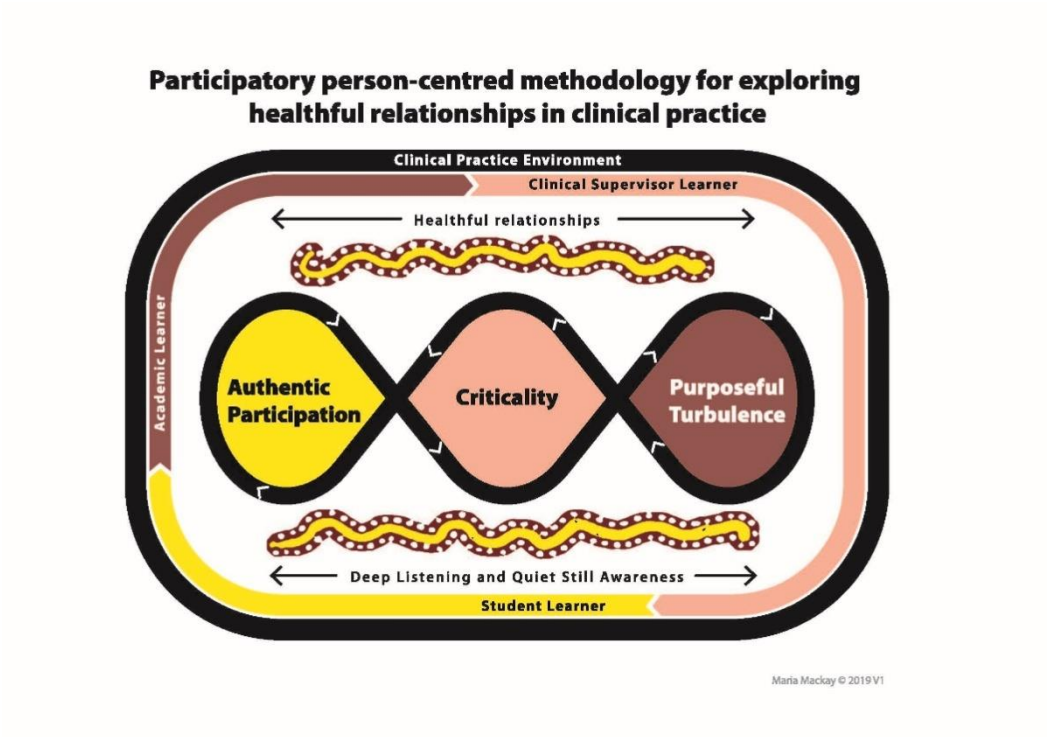


Image 7-3 Participatory Person-Centred Methodology for Exploring Healthful Relationships in Clinical Practice (2018)

In the framework above (Image 7-3) the concept of Dadirri as explored in a poem by Aunty Miriam Rose Ungunmerr (1988), beautifully describes contemplation as a way of embracing reflection through ‘inner deep listening and quiet still awareness’. These concepts and the colours representing Australian Aboriginal people have been used to create the methodological framework for this PhD research. When I consider this framework, I see calmness and connection, and I believe it characterises creating healthful relationships such as mutual respect, shared understanding and shared decision making. To capture the true essence of Dadirri, an explanation of the Aboriginal meaning of Dadirri and the full poem is in Chapter 3.

The infinity circle in the methodological framework (see Image 7-3) represents action and creativity. Person-centred research can be seen to be aligned with practice development principles and action-orientated approaches to research. Practice development considers the use of creativity through active learning to raise consciousness to the issues that require people to contemplate and problem solve (Dewing 2010). The use of person-centred and action-orientated approaches to research has been argued to bring about enlightenment and emancipation of communities (McCormack and McCance 2017). Creativity and action-orientated approaches were embedded in my PhD research throughout the process, from planning to the dissemination of the thesis. The colours and Aboriginal art within the methodological framework represent both the integration of Dadirri as an underpinning influence and represents my culture as a proud Australian Aboriginal woman. Image 7-3 represents for me the bringing together of the student, clinical supervisor and academic staff and the development of healthful relationships. The defining of healthful relationships in the context of a student and clinical supervisor relationship forms part of the PhD research and is shared in chapter 10.

Each section of the methodological framework (Image 7-3) will now be explored individually.

Clinical practice environment

Image 7-4 Clinical Practice Environment (2018)

The research for this PhD was undertaken with an education perspective however it also had an impact at the point of care, that is the clinical practice environment (see Image 7-4). Both students and clinical supervisors participated in education that informed their preparation for participation in clinical practice environment during a 10-day clinical placement in the health care or '*swampy lowlands*' environment (McNiff and Whitehead 2011). This PhD research was impacted by the swampy lowlands of clinical practice; therefore, it was important for students and clinical supervisors as co-researchers to consider the challenges melding the reality of educational and healthcare learning. This PhD research intended to explore relational processes and outcomes in the form of healthful relationships that occur in the clinical practice environment. In addition, it is hoped that this PhD research will inform the development of content for an undergraduate Bachelor of Nursing program and provide insight into the impact of developing healthful relationships between students and clinical supervisors.

The publics in the research - student, clinical supervisor and academic staff

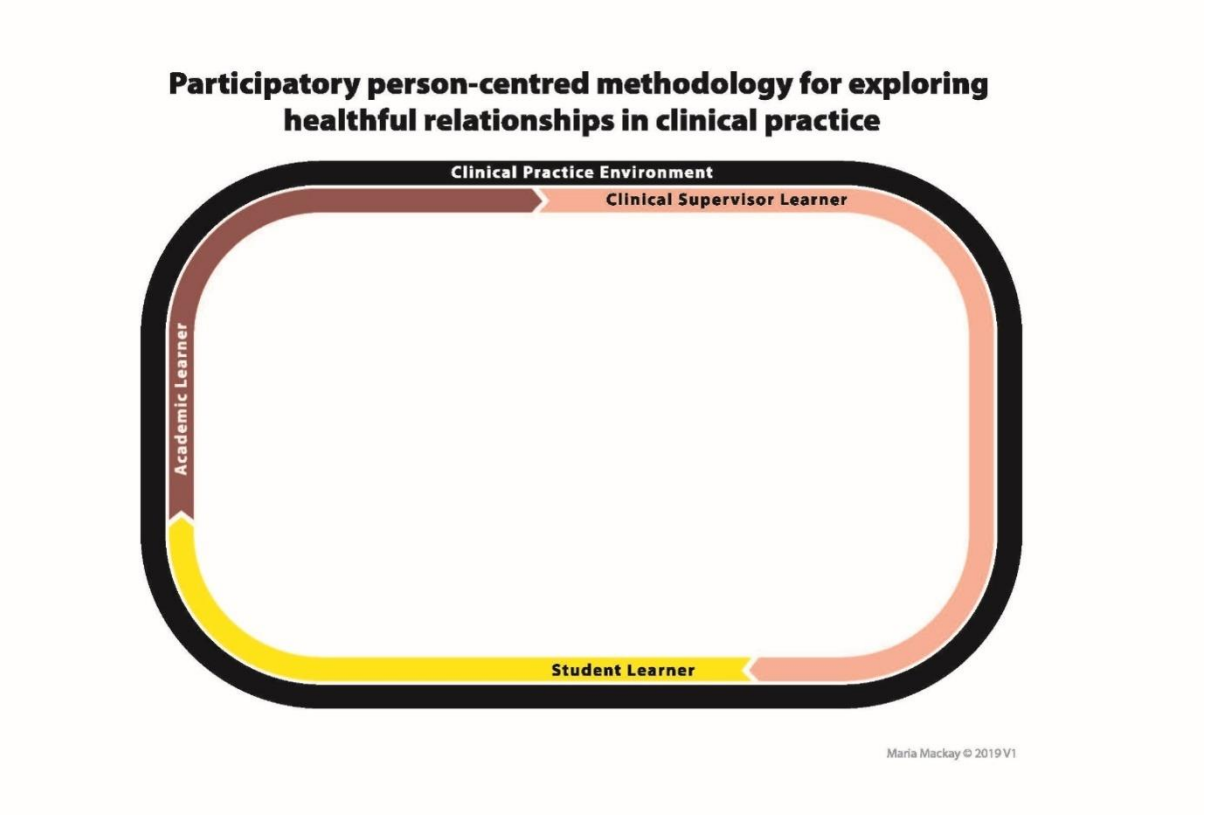


Image 7-5 The Participants or Publics Within the PhD Research (2018)

The participant groups within this PhD research or 'publics' are students and clinical supervisors (see Image 7-5). The academic staff were researchers and participated both within the PhD research and from a process perspective with those who choose to be more involved as co-researchers.

The following words from the Dadirri poem provide context for the participants or publics within the PhD research:

> We know that our white brothers and sisters carry their own particular burdens. We believe that if they let us come to them – if they open up their minds and hearts to us. We may lighten their burdens. There is a struggle for us, but we have not lost our spirit of Dadirri (Ungunmerr 1988).

Opening up of hearts and minds will enable persons to participate in and undertake this research authentically. Each group had the opportunity to define their role and each person maintained the right to determine how they participate. Although the

groups never connected as one, they maintained a connection with the research and were provided with the opportunity to validate the discoveries that were found along the PhD journey.

Healthful relationships

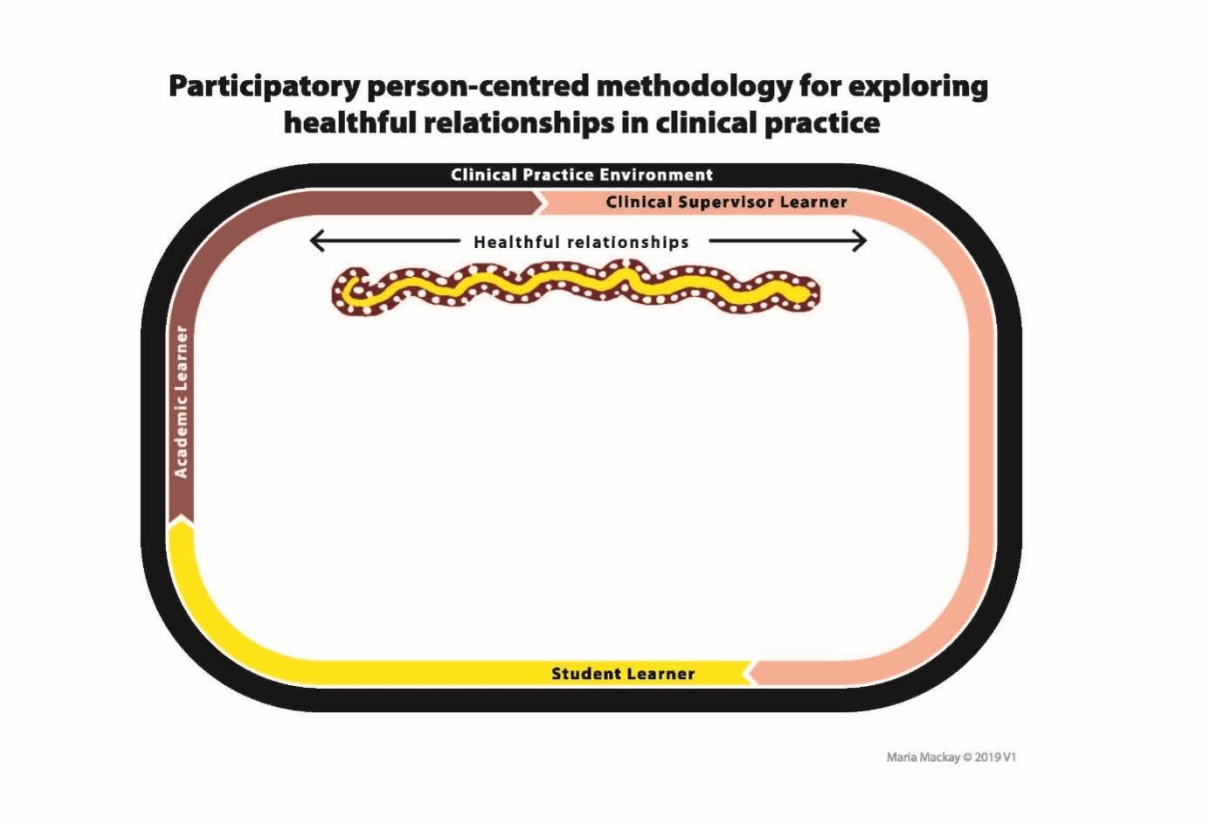


Image 7-6 Healthful Relationships (2018)

From a theoretical perspective, within the outcomes of the Person-centred Practice Framework (McCormack et al. 2017, p. 193), the "creation of healthful cultures is underpinned by healthful relationships" (see Image 7-6). As described earlier in this thesis in Chapter 4, these relationships are based on mutual respect, shared decision making and is a relationship that 'contributes to the promotion of health.' There is little evidence regarding the term healthful relationships and this PhD research aims to contribute to the evidence base about the relationship between students and clinical supervisors. Reflecting on the Dadirri poem, the following quote reflects the challenges and complexity of creating relationships:

> Our people are used to the struggle and the long waiting. We still wait for the white people to understand us better. We ourselves have spent many years learning about the white man's ways; we have learnt to speak the white man's language; we have listened to what he had to say. This learning and listening should go both ways. We would like people in Australia to take time and listen to us. We are hoping people will come closer. We keep on longing for the things that we have always hoped for, respect and understanding' (Ungunmerr 1988).

Authentic participation influences the creation of healthful relationships, as the participants were for some, both the researcher and the researched. The term healthful relationships has been placed across the theoretical framework with a double arrow to demonstrate that being mindful of the creation of healthful relationships is important from the beginning of the research to the end, including the dissemination of the thesis. The concept of participants being co-researchers and being involved with the co-creation of the research is important to consider. Kemmis et al. (2013) argue that participation in research should enable participants and co-researchers to have a free voice, one that reflects their value and what they believe is true. The outcome of developing healthful relationships between students and clinical supervisors in clinical practice is the "Aristotelian concept of eudaimonia or human flourishing" (Eide et al. 2017, p.193). The determination of human flourishing will be undertaken by each of the participants in keeping with the definition of personhood proposed in the previous chapter, where each person determines their own personhood. Thus, they determine if and when they experience human flourishing. Therefore, the methodological principle related to healthful relationships is that people who participate in this research have innately within their ability to flourish to their full potential both as participants and co-researchers.

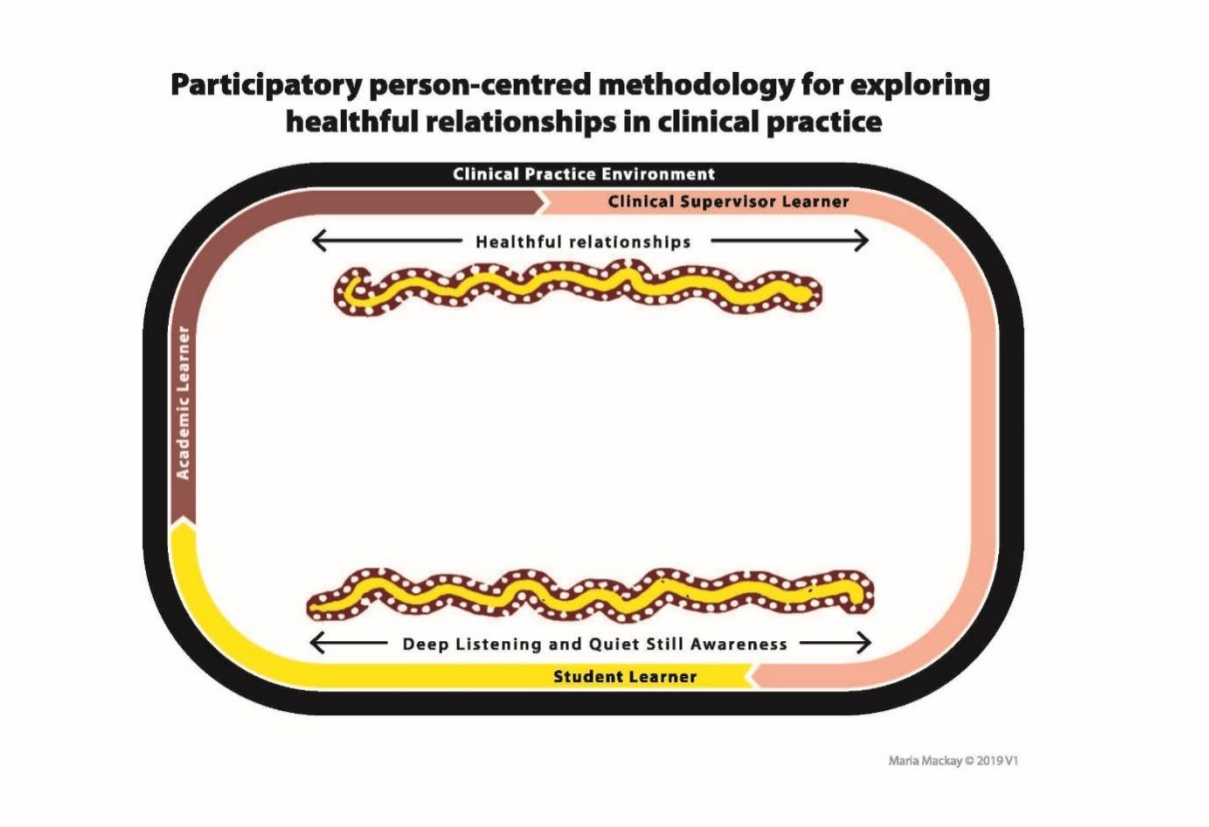


Image 7-7 Deep Listening and Quiet Still Awareness

The Dadirri Poem is embedded through this chapter and within the methodology framework (see Image 7-7). Specifically, Dadirri from an Australian Aboriginal perspective means contemplation. This part of the poem spoke to me regarding the contemplative or reflexive way of Dadirri for this PhD research:

> A special quality, a unique gift of the Aboriginal people, is inner deep listening and quiet still awareness. Dadirri recognises the deep spring that is inside us. It is something like what you call contemplation. …The contemplative way of Dadirri spreads over our whole life. It renews us and brings us peace. It makes us feel whole again. In our Aboriginal way, we learnt to listen from our earliest times. We could not live good and useful lives unless we listened (Ungunmerr 1988).

Reflexivity in action is defined in the context of person-centred research by Titchen et al. (2017, p. 35) as "Introduced to ... new ideas, my pre-understanding was challenged and broadened to include holistic understanding and meaning making systems." Titchen's ideas of reflexivity align with Mezirow's (1978) definition, however, in his work Mezirow describes reflexivity as being essential for transformative learning.

Mezirow (1978) explores critical reflection as a tool that is required to reflect on our held assumptions. I believe this is an ongoing issue for all people, and we firmly hold our assumptions often in a way that is unknown to us. It is the process of broadening our pre-understanding or creating self-awareness of the assumptions we hold, that enables reflexivity to be practised. Reflection is a tool that creates consciousness raising and unearths truths that were once unknown to us, it is in the discomfort of this where we hold the courage to remain curious that we practice reflectivity and gain new learning perspectives that transform our way of being in the world we live in. For me personally, I continue to strive to remain aware that all thoughts are assumptions, however, I continually find myself accepting truths that are assumptions and feel discomfort when my consciousness is raised.

As a researcher undertaking research within the critical paradigm, I was mindful of my role within the research team. My role as DCL comes with positional power that required to be acknowledged and respected by me whilst participating as the lead researcher. As part of my journey within this PhD research, I have considered the world view I brought into the research and how this may have potentially influenced the outcomes of the research. I remained mindful of my role in the university and the assumptions I held. Reflexivity was introduced into the practice of the team to enable self-awareness and analysis of our roles and ensure all co-researchers participated in the reflective nature of the paradigm (Coghlan and Brannick 2014).

More broadly, deep listening and quiet still awareness were integrated at each point of the research process. It was through reflexivity that as co-researchers we designed the methods and considered the information gathered. The process of deep listening and quiet still awareness ensured we remained true to our personal and collective values. The outcomes of the research reflected the needs of the participants, not the expert researchers. It was, therefore, a methodological principle that contemplation was embedded into the Knowing, Doing and Being as a participant and co-researcher in this PhD research.

Authentic participation

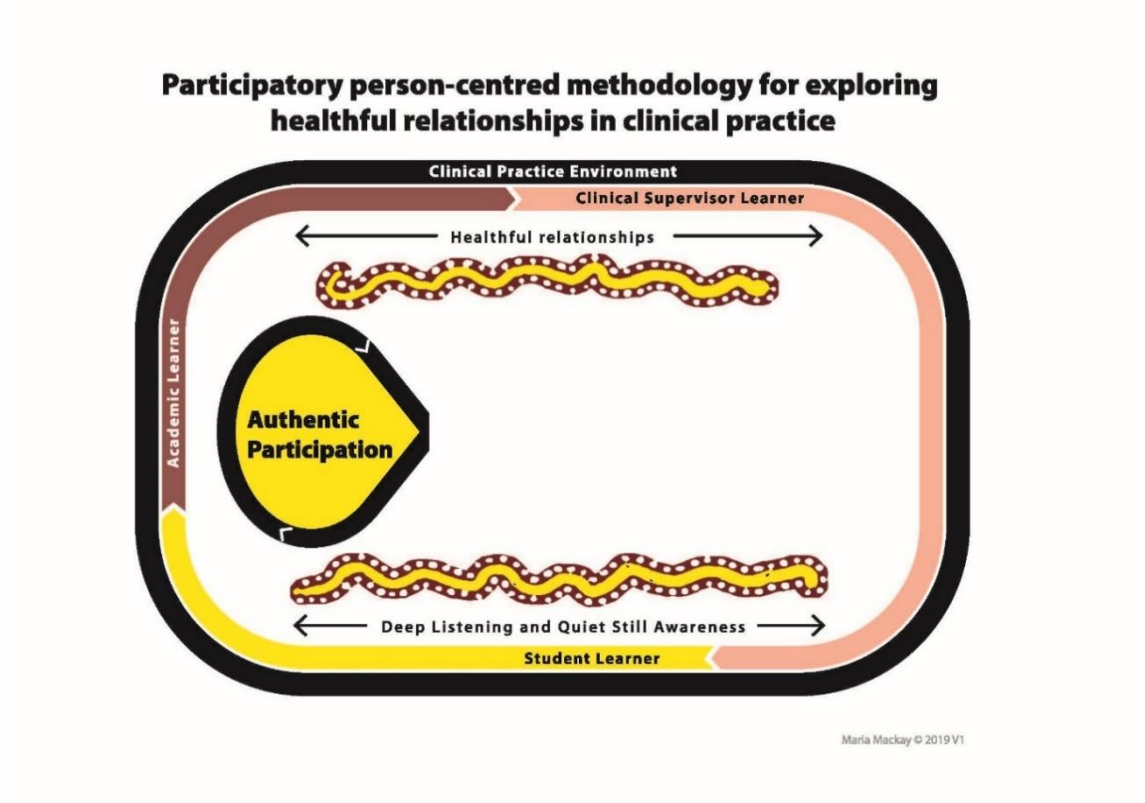


Image 7-8 Authentic Participation (2018)

Authentic participation is a complex concept (see Image 7-8). Participation in research has its origins in community development research. It is recognised that the community members needed to be involved within the research to enable the outcomes to meet their needs and be sustainable (Le Dantec and DiSalvo 2018). Progressing the concept of participation to authentic participation, the intent of the community-based research, I would suggest is to achieve authentic participation. Although participation is argued by McCormack et al. (2017) to be inherent in person-centred research, I have separated the concept of authentic participation to ensure it was prominent in how this research was planned and implemented. A current criticism in traditional research is that participatory approaches continue to do to rather than to do with the researcher (Kemmis et al. 2013; Reid 2012). I would argue that by using authentic participation this provides the intent that the participant is involved in the co-design of the research from the beginning to the end of the process and is potentially a co-researcher. Authentic participation is represented in the Dadirri Poem in the following way:

> We wait for our young people as they grow, stage by stage, through their initiation ceremonies. When a relation dies we wait for a long time with the sorrow. We own our grief and allow it to heal slowly. We wait for the right time for our ceremonies and meetings. The right people must be present. Careful preparations must be made. We don't mind waiting because we want things to be done with care. Sometimes many hours will be spent on painting the body before an important ceremony. We don't worry. We know that in time and in the spirit of Dadirri (that deep listening and quiet stillness) the way will be made clear (Ungunmerr 1988).

Thus, undertaking the research required authenticity that included truly listening to participants and not rushing to just do, but taking time to allow people to have a voice that was heard and considered.

Authenticity in this context is defined by Brene Brown as a collection of choices we make every day. She further argues this is a practice that we need to be mindful of in our interactions and choices (Brown 2010). She further explores the concept of authentic practice and relates this to true belonging, which has been described within the philosophical framework chapter (see Chapter 6) and suggests that by being authentic, we choose to truly belong rather than fit in; this takes courage in our daily practices. Finally, Brown (2010) describes how she has moved from believing that people are either authentic or inauthentic, instead of believing that people are doing the best they can with what they have. With regard to authentic participation in this PhD research, the intent was to research with participants and for their participation to be authentic. The concept that people are doing the best they can with what they have was a concept that the research team embraced through creating shared values and ways of working. Consistent with this, participants maintained the option of being co-researchers, involved in all aspects of the research, from the planning and design through the implementation and the reflection on the outcomes of the research (Kemmis et al. 2013). A methodological principle that was embedded within this PhD research is that people have the right to authentically participate in this research in the way that is right for them. They maintain the power to change their contribution at any point within the research process.

Criticality

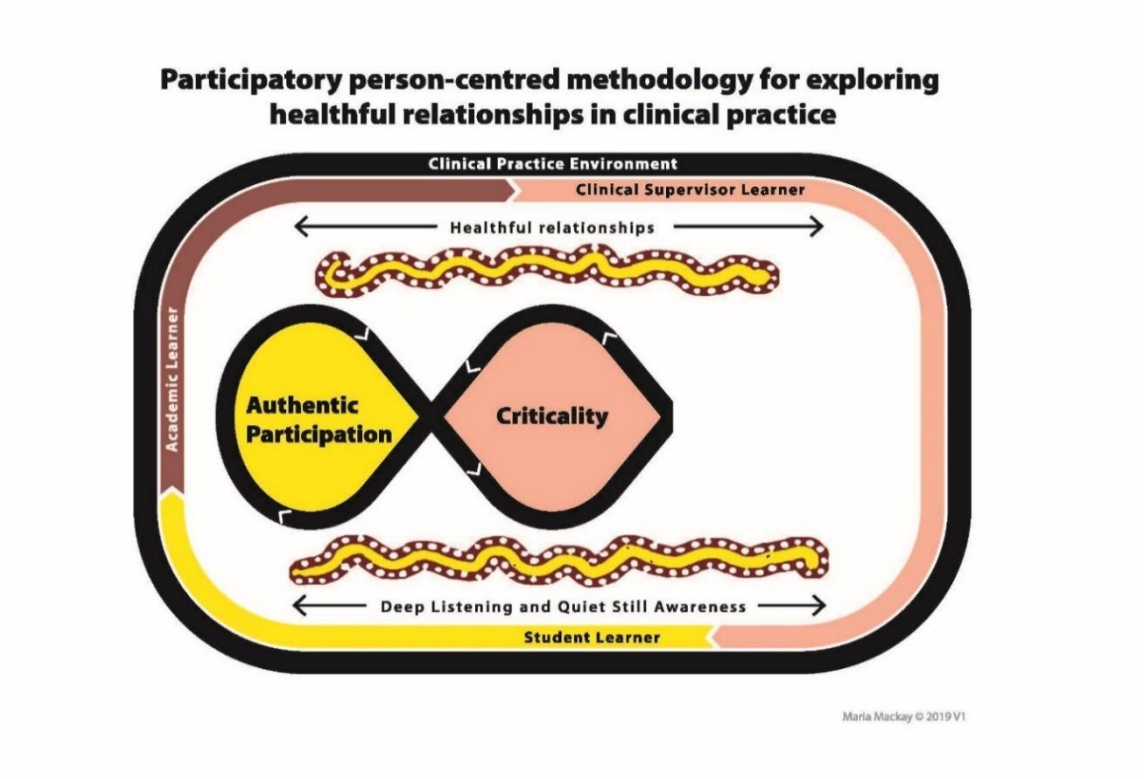


Image 7-9 Criticality (2018)

Criticality in the perspective of this PhD research (see Image 7-9) is embedded within critical reflection as described by Mezirow (1978). Mezirow (1978) considers transformational learning as a process of creating new learning perspectives. A learning perspective is the lens we take to a situation or learning experience. Through education, this lens is transformed to create a new learning perspective that was previously unknown to us (Mezirow 1978). For this PhD research, participants and co-researchers needed to have the courage to look below the surface and consider the layers that created a situation or relationship, challenging their existing assumptions. Through criticality and unpacking of these layers, the elements of healthful relationships were exposed. It takes courage and curiosity to be honest in what creates connections and how these impact on participants' ability to flourish to their full potential. The emergence of these elements occurred in the clinical practice environment and, as I envisaged, the cost of courage resulted in great rewards in the discovery of meaning within connectedness between students and clinical supervisors. My critical lens unearthed the elements that created the environment for transformational learning in clinical practice.

In line with the concept of having a deep critical lens, the Dadirri poem explains that:

> There are deep springs within each of us. Within this deep spring, which is the very spirit, is a sound. The sound of Deep calling to Deep. The time of re-birth is now. If our culture is alive and strong and respected it will grow. It will not die and our spirit will not die. I believe the spirit of Dadirri that we have to offer will blossom and grow, not just within ourselves, but in our whole nation (Ungunmerr 1988).

Therefore, it was a methodological principle in this PhD research that participants and co-researchers have the courage and curiosity to explore the layers of the relationships they developed during a clinical placement considering how these impact their ability to realise human flourishing.

Purposeful turbulence

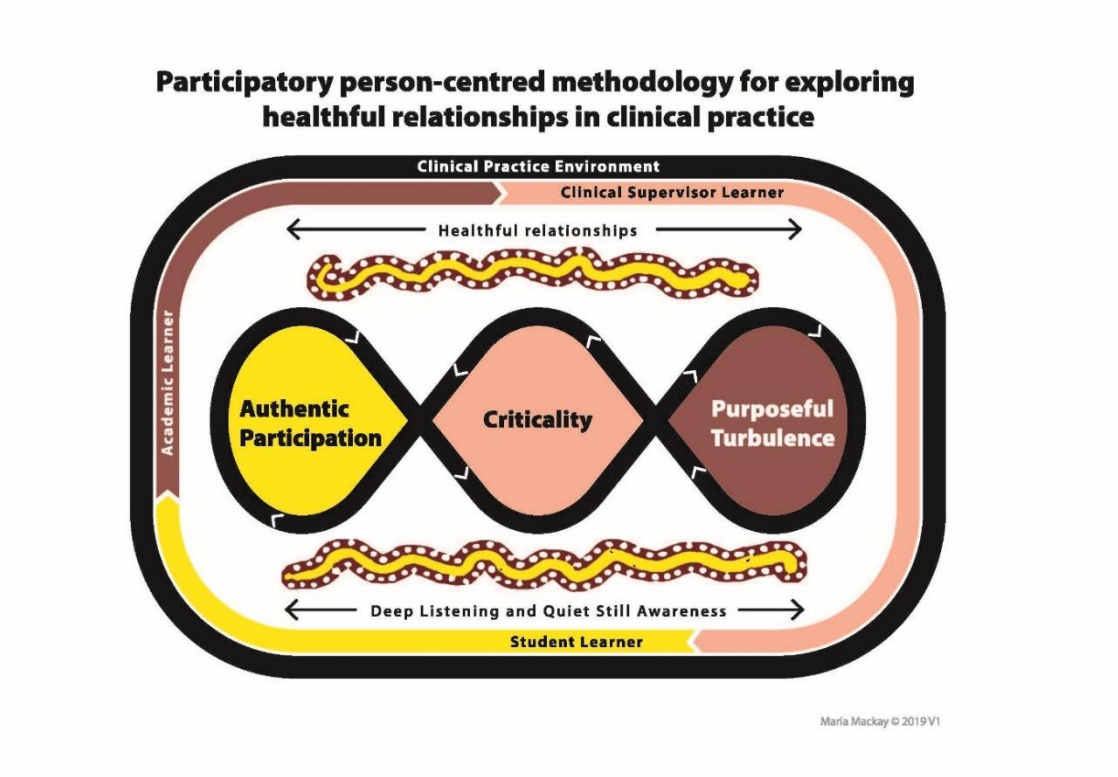


Image 7-10 Purposeful Turbulence (2018)

From my experiences, students enter clinical practice often feeling unsure and anxious. Their anxiety comes from them entering an environment that is unknown and complex in nature. The complexity of clinical practice has many layers; ultimately this complexity comes from the unpredictability of challenges nurses face in meeting the

individual health needs of those they care for. Therefore, I saw purposeful turbulence (see Image 7-10) as when people in the healthcare environment thrash around in clinical practice responding to issues as they arise with intention of shared learning. On the other hand, turbulence is when there is a complexity that creates a sense of chaos in the clinical practice environment without the intention to survive rather than learn from the actions within the chaos. It is the movement of turbulence from chaos to one that enables learning that transforms it to become purposeful turbulence. Shared learning occurs within the thrashing of purposeful turbulence. Students come with knowledge, both known and unknown to them. They are then faced with issues and challenges and use their knowledge and the knowledge of others around them to unpack whatever they are faced with, problem solve and evaluate the outcomes of actions they both do and observe. Clinical supervisors also come with knowledge and they utilise this in facilitating the learning of themselves and the students they are supervising in clinical practice. Knowledge in purposeful turbulence is gained from the people they care for, their carers, the interdisciplinary team and themselves. Some authors (Mezirow 1978; Titchen et al. 2001) suggested that knowledge is created from Doing or actions. I suggest that new knowledge is created from Knowing, Doing and Being, and this new knowledge is transformational and demonstrated in an experience of human flourishing or Becoming.

I would suggest that purposeful turbulence is required for learning to occur in the clinical practice environment. Learning for students and clinical supervisors should be active and more than just skills-based learning. This learning involves them immersing themselves into a clinical practice environment, being open to learning both from the a concept of Doing and Being and considering what they already know with regard to a given situation and seeking new knowledge in reflecting on how to best understand the way forward. Dadirri in the poem expands on learning in turbulence being purposeful by describing:

> We don't worry. We know that in time and in the spirit of Dadirri (that deep listening and quiet stillness) the way will be made clear. We are like the tree standing in the middle of a bushfire sweeping through the timber. The leaves are scorched and the tough bark is scarred and burnt, but inside the tree the sap is still flowing and under the ground the roots are still strong. Like that tree we have endured the flames and we still have the power to be re-born (Ungunmerr 1988).

The challenge students present to registered nurses and their clinical supervisors is how can they stay true to their values and transform turbulence encountered into purposeful turbulence. Students in this process need to have the courage to belong to themselves in their actions and behaviours (Angelou and Elliot 1989; Brown 2010) and not participate in clinical practice that they know is not aligned to policy or evidence-based. The methodological principle that therefore applies to this PhD research is all turbulence in clinical practice has the potential to transform into purposeful turbulence enabling students, clinical supervisors and academic staff to realise belonging and transformative learning.

Chapter Summary

In summary, the following methodological principles (in no particular order) will guide me with all aspects of the research process:

Principle 1 Human Flourishing (McCormack and McCance 2017)

- Persons who participate in this research have innately within them the ability to flourish to their full potential both as participants and as co-researchers.

Principle 2 Power within social relationships (Habermas 1987)

- Persons who participate in this research have the right to authentically participate in this research in the way that is right for them and they maintain the power to change their contribution at any point within the research process.

Principle 3 Courage and Curiosity (Brown 2018)

- Persons who participate in this research have the courage and curiosity to explore the layers of the relationships they develop during a clinical placement considering how this impacts on their ability to realise human flourishing.

Principle 4 Transformative Learning (Mezirow 2000)

- That all turbulence in clinical practice has the potential to transform into purposeful turbulence enabling student, clinical supervisor and academic staff

to realise true belonging and transformative learning.

Principle 5 Contemplation (Ungunmerr 1988)

- That contemplation is embedded into the Knowing, Doing and Being as a participant and co-researcher in this PhD research.

The learnings from this chapter for me were to be open to what was presented to me. I spent time considering the methodological framework I brought into this research. I undertook a process with potential participants that are described in the next Chapter 8, enabling me to become clearer on what a person-centred methodology could look like. It was not until I embraced the Dadirri poem again and contemplated how this spoke to me and enabled me to combine my want to have a person-centred methodology with ancient Indigenous knowledge that I felt I was able to develop a methodological framework that I believe authentically represented me as a person-centred researcher, and my participants and co-researchers.

This chapter moved the research to a point where it was ready for implementation through the application for ethical approval and collection of information. The following Chapter 8 now builds on the methodology discussing the methods that were utilised and part one of the information collection.

I am ending this chapter with the full version of Dadirri as this speaks to my Indigenous person-centred methodology perfectly (see Image 7-11). (Poem shared with permission from the Miriam Rose Foundation).

Dadirri

Listening to one another (The Aboriginal Way)

Inner deep listening and quiet still awareness.

Edited version adapted from the writings of Miriam-Rose Ungunmerr.

Dadirri. A special quality, a unique gift of the Aboriginal people, is inner deep listening and quiet still awareness. *Dadirri* recognises the deep spring that is inside us. It is something like what you call contemplation.

The contemplative way of *Dadirri* spreads over our whole life. It renews us and brings us peace. It makes us feel whole again. In our Aboriginal way we learnt to listen from our earliest times. We could not live good and useful lives unless we listened.

We are not threatened by silence. We are completely at home in it. Our Aboriginal way has taught us to be still and wait. We do not try to hurry things up. We let them follow their natural course – like the seasons.

We watch the moon in each of its phases. We wait for the rain to fill our rivers and water the thirsty earth. When twilight comes we prepare for the night. At dawn we rise with the sun. We watch the bush foods and wait for them to open before we gather them.

We wait for our young people as they grow, stage by stage, through their initiation ceremonies. When a relation dies we wait for long time with the sorrow. We own our grief and allow it to heal slowly. We wait for the right time for our ceremonies and meetings. The right people must be present. Careful preparations must be made. We don't mind waiting because we want things to be done with care. Sometimes many hours will be spent on painting the body before an important ceremony.

We don't worry. We know that in time and in the spirit of Dadirri (that deep listening and quiet stillness) the way will be made clear.

We are like the tree standing in the middle of a bushfire sweeping through the timber. The leaves are scorched and the tough bark is scarred and burnt, but inside the tree the sap is still flowing and under the ground the roots are still strong. Like that tree we have endured the flames and we still have the power to be re-born.

Our people are used to the struggle and the long waiting. We still wait for the white people to understand us better. We ourselves have spent many years learning about the white man's ways; we have learnt to speak the white man's language; we have listened to what he had to say. This learning and listening should go both ways. We would like people in Australia to take time and listen to us. We are hoping people will come closer. We keep on longing for the things that we have always hoped for, respect and understanding.

We know that our white brothers and sisters carry their own particular burdens. We believe that if they let us come to them – if they open up their minds and hearts to us. We may lighten their burdens. There is a struggle for us, but we have not lost our spirit of Dadirri.

There are deep springs within each of us. Within this deep spring, which is the very spirit, is a sound. The sound of Deep calling to Deep. The time of re-birth is now. If our culture is alive and strong and respected it will grow. It will not die and our spirit will not die. I believe the spirit of Dadirri that we have to offer will blossom and grow, not just within ourselves, but in our whole nation.

Experiencing Dadirri

Clear a little space as often as you can, to simply sit and look at and listen to the earth and environment that surrounds you. Focus on something specific, such as a blade of grass, a clump of soil, cracked earth, a flower, bush or leaf, a cloud in the sky or a body of water (sea, river, lake) whatever you can see. Or just let something find you be it a leaf, the feel of the breeze, the light on a tree trunk. No need to try. Just wait a while and let something find you. Lie on the earth, the grass, some place. Get to know that little place and let it get to know you- your warmth, feel your pulse, hear your heart beat, know your breathing. Just relax and be there, enjoying the time together. Simply be aware of your focus, allowing yourself to be still and silent..., to listen. Following this quiet time there may be, on occasion, value in giving expression in some way to the experience of this quiet, still listening. You may wish to talk about the experience or journal. This needs to be held in balance - the key to Dadirri is in simply being, rather than in outcomes and activity.

In greeting each morning, remind yourself of Dadirri by blessing yourself with the following..."Let tiny drops of stillness fall gently through my day "*Noel Davis*

Image 7-11 Dadirri Poem (Ungunmerr 1988).

Chapter 8

Continuing the Journey to Methods and Information Collection

Image 8-1 Continuing the Journey to Methods and Information Collection - © Maria Mackay 2020

Introduction

In the previous chapter, I outlined the person-centred participatory methodology that informed the development of the methods within this PhD research. In this chapter, I begin the chapter by building on the methodological model and provide an overview of the research information methods that were utilised in the collection of information. The image (see Image 8-1) above demonstrated creatively the part of my road where I continued to methods and information collection. Being true to person-centred participatory approach, the methods were designed and developed with a group of potential participants. Initially, in this chapter, I describe and justify the methods used in this part of the research process. I then move along the road further and explore the two rounds of information collection that occurred. This chapter focuses on part one of the information collection where participants, both students and clinical supervisors, shared information from their experiences during a 10-day clinical placement. The first information collection round was titled Beginning to Listen and Wait with Patience. These are words from the Dadirri poem that illustrate the need to learn to listen and

not hurry the process, as a person-centred researcher, for the information that is right to emerge. The second round of information collection and was titled Learning Patience and Not to Worry. This second round again was titled using words from Dadirri, emphasising the vulnerability that comes with the person-centred research. Following each round of information collection, some of the participants agreed to be co-researchers and undertake a process of synthesis of the information collected, this part of the research process is shared in Chapter 9. Chapter 10 then moves to the synthesis and meta-synthesis of the information. It combines the information collected to address what a healthful relationship is and how this influences person-centred transformational learning. These stages of the research process are captured in Image 8-2 below where the overall research process is described.

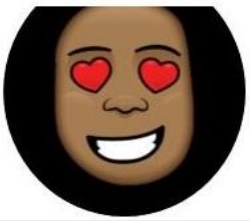
Part One, Round Two	Research Process	Methods
• 16 September 2019 to 18 December 2019 	•Participant Recruitment •Introduction Workshop •Information Collection using Emoji •Individual Informal Interviews •Synthesis with Co-researchers	•Creating ways of working, contemplation, emoji, critical dialogue, critical reflection and informal conversation group interview
Part One, Round One	**Research Process**	**Methods**
• 3 July 2019 to 9 August 2019 	•Participant Recruitment •Introduction Workshop •Information Collection using Emoji •Individual Informal Interviews •Synthesis with Co-researchers	•Creating ways of working, contemplation, emoji, critical dialogue, critical reflection and informal conversation group interview
Part Two	**Research Process**	**Methods**
• 20 January 2020 to 5 February 2020 	•Participant Recruitment •Introduction Workshop •Information Collection using Emoji •Individual Informal Interviews •Synthesis with Co-researchers	•Creating ways of working, contemplation, critical dialogue, critical reflection and informal conversation group interview
Discoveries through Synthesis 	**Research Process**	**Methods**
	•Bringing together the voices of the student and clinical supervisor synthesis process •Validation of the models and discoveries with co-researchers •Validation through expert opinion	•Contemplation, critical dialogue, critical reflection

Image 8-2 A Summary of the Research Process

I conclude this chapter with the ethical considerations that have arisen throughout this part of my research, considering the actual and potential impacts the journey has had on the participants and myself.

Person-centred Methodology

As discussed in the previous Chapter 7, the methodological model that was developed for this PhD research and titled Person-centred Methodology for Healthful Relationships in Clinical Practice (see Image 8-3) were created following exploration of my ontological and epistemological principles (see Chapter 7) to align with the way I see and understand the world and with how I will approach being a researcher. This person-centred methodological model has underpinned the development of methods, information collection and the synthesis of information within this PhD research. The model is positioned here to ensure alignment with the methods and information collection shared within this chapter.

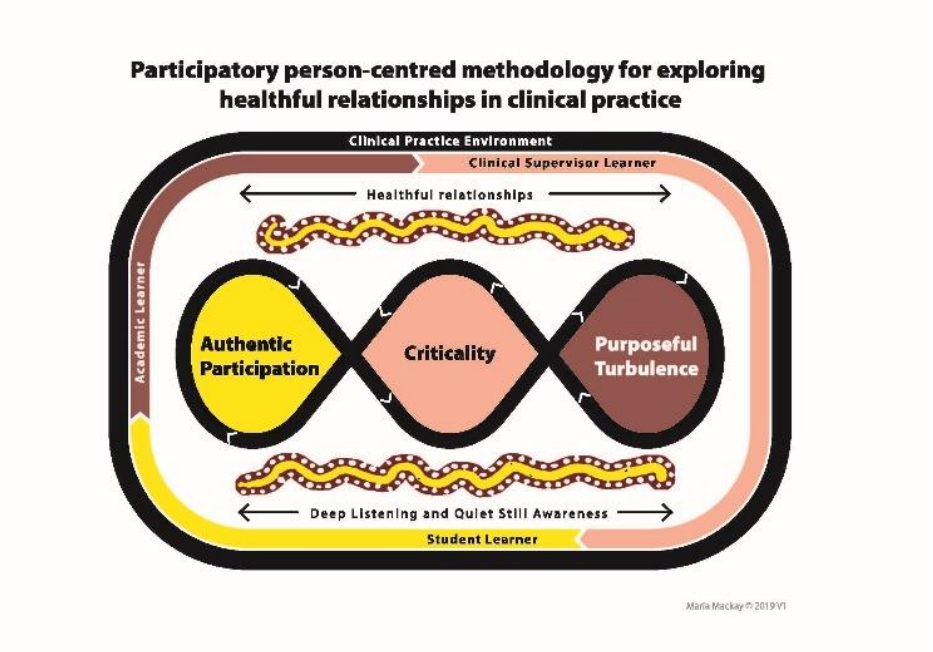


Image 8-3 Participatory Person-Centred Methodology for Exploring Healthful Relationships in Clinical Practice (2018)

Information Collection Methods in Action

The information collection methods within this PhD research were co-developed with potential participants. As discussed in Chapter 5, after completing a reflection on the book titled 'The Research Planner: Doing Critical Participatory Action Research'

(Kemmis et al. 2013), I developed a process for enabling potential participants to be part of the planning phase of this PhD research. In March 2017, I undertook 2 methods development workshops with potential participants who would meet the criteria to participate in the PhD research. One of the workshops was with students who were in year 1 of the BN in 2017 and the second was with clinical supervisors who were employed by the University where this PhD research was undertaken. As part of the workshop, I asked a series of questions that the potential participants responded to in groups. The questions in the workshop were:

- What information/evidence/data would you need to answer the questions?
- How would you make sense of / analyse this information/evidence/data?
- Using the criteria of being participatory and creative re-consider how would you gather this information?
- What barriers/challenges would you see in collecting and analysing information in this way?

Following the process of consideration of the questions, each group agreed on the information collection and synthesis strategies. As previously stated, this PhD research was situated within a person-centred methodology and embedded a variety of participatory and creative research methods. The methods, as outlined below in (see Image 8-4) included creating ways of working, inner deep listening and quiet still awareness, critical dialogue, critical reflection, creativity and active learning. The methods and tools that were used within this PhD research and the informing paradigms are documented in the image (see Image 8-4) below:

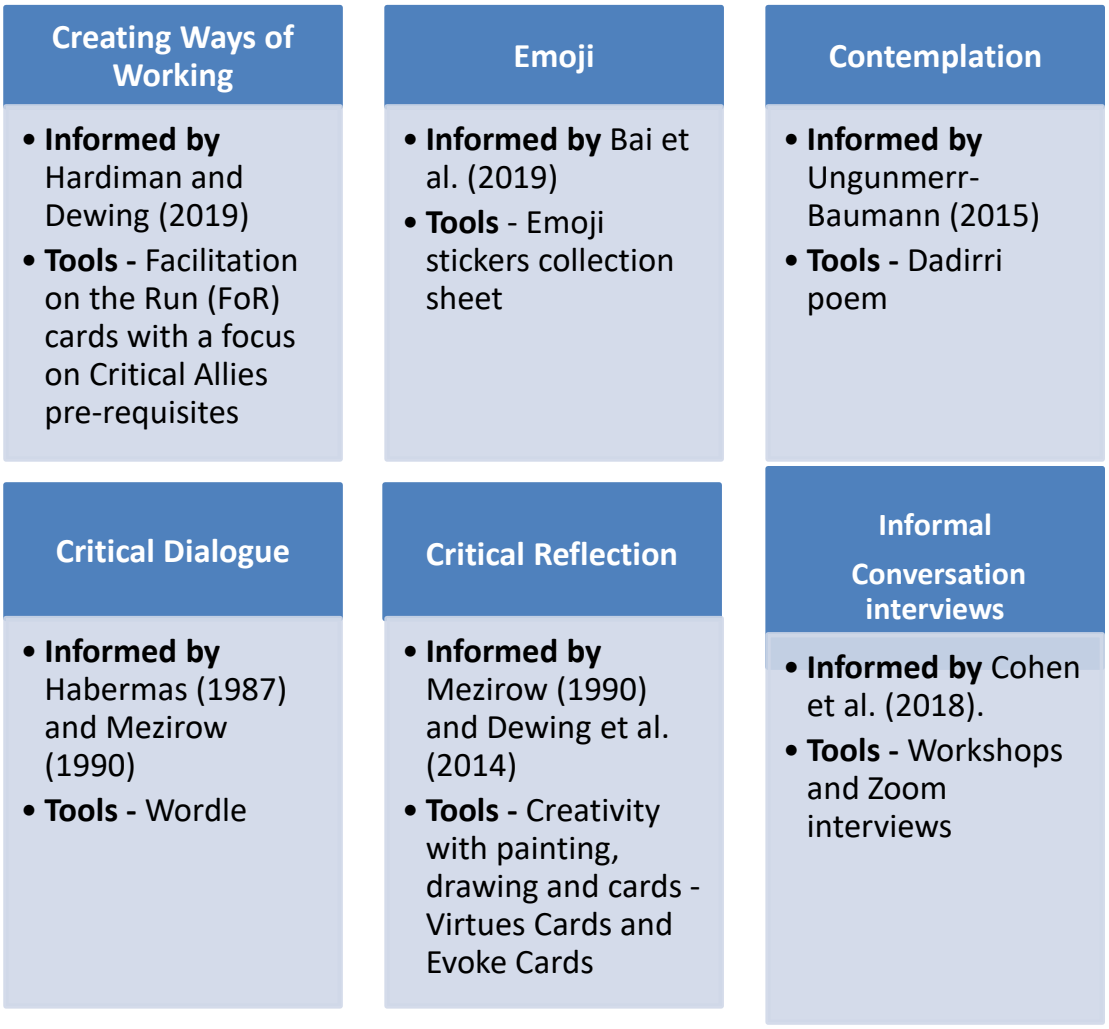


Image 8-4 Research Methods and Tools (2020)

In this section of the chapter, I present a theoretical overview of the methods used and then in the next section, apply these methods to each of the research processes undertaken in part one.

Creating ways of working

Creating ways of working is consistent with working in person-centred ways with participants. Creating ways of working is informed by Habermas (1987) through his work on Critical Dialogue and establishing the pre-requisites from Facilitation on the Run (FoR) (Hardiman and Dewing 2019). Creative ways of working were established each time when I met with participants and co-researchers. Creating ways of working is an important part of creating mutual consensus and creating safe spaces (Habermas

1987) to enable authentic participation. Consistent with participatory ways of researching (Kemmis et al. 2013), it is important to provide the participants with a voice within the research process at each point of connection. In my experience, ways of working can be overlooked, however, I would argue if we do not give a voice to all persons involved in the process, then we are Doing to persons, whereas we need to create ways of working so we are Doing with others.

Facilitation on the Run (FoR) (Hardiman and Dewing 2019) was used because it emphasises the establishment of pre-requisites using the Critical Allies Framework (Hardiman and Dewing 2019) (see Appendix H) as creative ways of working. This use of the pre-requisites focuses on creating a facilitative relationship and was developed between the participants, myself and the other academic staff member involved in a novice way as we were unfamiliar with each other (Hardiman and Dewing 2019). The Critical Allies Framework (Hardiman and Dewing 2019) has four areas of pre-requisites, namely shared values, authentic presence, mutual respect and preparedness. Using the Critical Allies Framework established a facilitative relationship; revisiting this each time we met ensured the relationship was authentic and recognised both our challenges and growth as a group (Hardiman and Dewing 2019). Revisiting our ways of working was an important step as it enabled our group to ensure our ways of working did not become a process where assumptions were made or where ways of working were an inflexible fixed agreement.

Emoji

The use of emoji as a research tool was explored within the literature review submitted for publication and outlined in Chapter 5. Found within this scoping review, emoji's use as an information collection tool was not well established and its connection to person-centred research was not understood (Bai et al. 2019). However, there was evidence that emoji enables persons to connect with their emotions and is a useful tool to enable participants to reflect on and express their feeling about a topic or issue (Willoughby and Lui, 2018; Bai et al. 2019). It is hoped that using emoji within this PhD research adds to the current knowledge base of their use as an information collection tool.

Within this PhD research, the earlier research project with students, 'Enabling nursing students to participate in designing an educational resource to support their participation within clinical practice' (see Appendix D), found that connecting to emotions enabled the creation of relationships. Emoji (Bai et al. 2019) was used with participants in part one where they were required to identify a positive and challenging aspect of their relationship each day whilst on clinical placement. A copy of the sticker sheet was provided for each participant (see Image 8-5) with a short space for them to document their experience each day. The use of emoji (Bai et al. 2019) related to the person-centred methodology within this research in the areas of healthful relationships and criticality. Connecting to their emotions enabled participants to critically consider what was working and where they faced challenges in the creation of relationships with others.

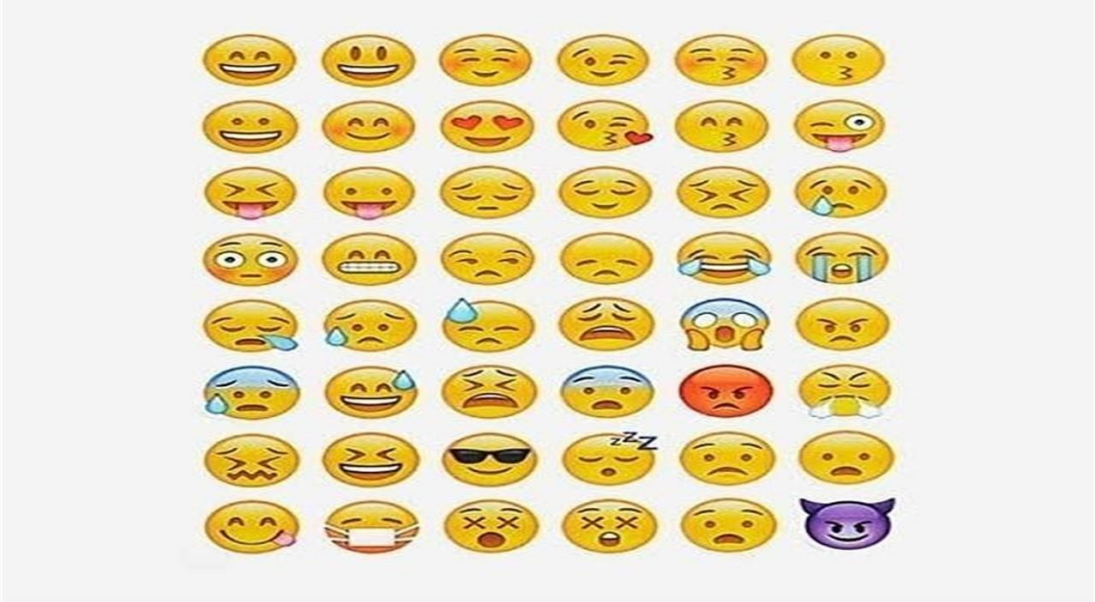


Image 8-5 Emoji Sticker Sheet (2020)

Contemplation

Contemplation, a construct of inner deep listening and quiet still awareness is derived from the Dadirri poem (Ungunmerr 1988). It can be related to the work of Mezirow (2000), his concept of critical reflection, however moving away from the western view of reflection it provides the Indigenous perspective of embodied reflection in contemplation and deep listening (Andrews 2019; Oliveros 2005). Contemplation

differs from the term critical reflection with both forms of reflection used as methods within this PhD research (Mezirow 1990). Critical reflection as described later in this chapter is a process for reasoning or making sense of an issue or dilemma. Contemplation in the Australian Aboriginal sense is related to Dadirri and is listening with your heart, mind and soul (Andrews 2019). Andrews (2019, pp. 40-41). further describes how "Aboriginal people are taught this from an early age and if used wisely it is a leadership tool that enables the creation of safe space." Significant in its own right, deep listening focuses energy on connection (Andrews 2019), with its adoption used here as an information collection tool in this PhD research.

As discussed in the previous chapter, Dadirri underpins much of the methodological framework within this PhD research (see Chapter 7). I believe the concept of Dadirri is a pearl of ancient wisdom within the Australian Aboriginal culture that Aunty Miriam Rose Ungunmerr (2015) illuminated in her poem. I feel so attuned to the way she describes how we should consider living our lives with patience and grace and allow things to unfold as nature has planned. Taking time for inner deep listening and quiet still awareness within our lives, Ungunmerr (2015) believes that for Dadirri to enrich us and allow us to unearth the gems, we need to have a full and peaceful life. Purposefully, I have integrated Dadirri within the methodology and methods of this PhD Research as a process of contemplation (Ungunmerr 1988). This notion of contemplation is also drawn from the work of McCormack and Titchen (2006, p. 259); they cultivate the concept of critical creativity as having sacred dimensions. From an Australian Aboriginal perspective, when we walk on sacred land we must be 'focussed, attentive and prepared in every sense, mentally and physically' (Andrews 2019, p. 54). Listening deeply with our dreaming ears (Andrews 2019) brings together the ancient wisdom of Aboriginal culture with the concept of embodied and imaginative knowing through connection with the ancient wisdom of critical creativity (Titchen and McCormack 2010, p.253).

The practice of Dadirri as a form of contemplation can be used in many ways. For this research study, Dadirri has been practised as a method of contemplation and a time to reflect. The reading of the Dadirri poem was utilised as a focus for persons to bring

stillness to their mind. Once the poem was read (either in full or part), an individual or a group sat in silence for two to five minutes. This purposeful silence was used to enable inner deep listening and quiet still awareness or contemplation where thoughts that came to a person were heard, contemplated and considered. Any learnings from this process were then shared with others or documented.

Critical dialogue

Critical Dialogue is defined as an exchange that considers the assumptions or biases we hold when having conversations that seek to gain awareness, wisdom and understanding, these can be from an individual or group perspective (Schein 1993; Marchel 2007). Marchel (2007, p.7) further describes critical dialogue as having two considerations; "First, it pays particular attention to the role of personal bias, especially concerning patterns of power and privilege. Second, critical dialogue is a collaborative act in which peers assist each other in the mutual examination of biases." The definitions of critical dialogue as identified above have been influenced by transformational learning theory.

Similarly, this PhD has also embedded critical dialogue within the methodology and methods as a form of criticality from the perspective of Habermas's elements of rationality and mutual consensus and Mezirow's (1990) validity. Critical Dialogue from a Habermasian (1987) perspective is based on the concept of rationality and has already been discussed from multiple perspectives; ontological, epistemological (see Chapter 6) and methodological (see Chapter 7). From this viewpoint of dialogue, rationality assumes that all persons are rational and can change the way they see the world by being presented with alternative arguments. Mezirow (1990) considers rational discourse to be the conduit to critical reflection and perspective transformation. Critical dialogue forms part of the methods used within the information collection and synthesis of information as individually we are seeking understanding collectively, we were seeking a mutual agreement. There were many aspects that involved critical dialogue (Mezirow 1990), with the tool utilised to capture this being a Wordle in the pre-placement workshops. A Wordle is a cloud-based software, freely available, that allows words to be input into a program with the user

choosing the format the words are displayed in. The words that are larger and bolder in the Wordle are words most frequently input by the user. This form of software provides summary information (McNaught and Lam 2010).

Critical reflection

Critical reflection is embedded within the Theoretical Framework Chapter and the Methodological Model that informs the research process within this PhD as outlined in Chapters 6 and 7. Mezirow (1990, p. 88) depicts critical reflection as "appraisive rather than prescriptive or designative". He is influenced by Habermas in his consideration of critical reflection and further describes the complexity of adult learning, arguing that transformative learning requires a level of critical reflection to address both the instrumentation and communicative aspects of the emancipatory perspective of transformative learning (Mezirow 1990). Mezirow argues that critical reflection is an essential component of transformational learning as it is underpinned by learners reflecting on their accepted (or presupposed) assumptions. Specific to this PhD research, there is an emphasis on the participants sharing their views and feelings from their experience. To ensure this was undertaken critically, participants were encouraged to consider their assumptions and beliefs and how they represented the positive and challenging aspects of their relationships authentically. In the workshops, authentic participation and criticality were closely aligned as participants were required to be critically reflective, to enable them to bring their authentic voice to the group. Mezirow (1990) argues that transformative learning occurs through critical reflection on ones firmly held assumptions and acting on the knowledge we generate from the reflective process. The insights and actions the participants shared formed part of the information collection. Critical reflection was undertaken at many points in the research process, within the workshops, we utilised creativity such as painting and drawing and cards, such as Evoke and Virtues cards, to enable a connection with critical reflection (Dewing et al. 2014; Buckley 2017). The use of cards as a method for information collection and to spark critical reflection is consistent with practice development ways of working and a person-centred approach to research (Buckley 2017).

Informal conversation interviews

Informal conversation interviews (Cohen et al. 2018) within the information collection part of this PhD research were both individual and group interviews. The purpose for information conversational interviews is described by Cohen et al. (2018) as an interview where the questions are enabled to emerge from the context of the research and posed in the natural course of the conversation. They argue that this is appropriate for educational based research as the strengths of these types of interviews lie within the prominence and applicability of the questions to allow for the flow of the conversation. Informal conversation interviews can be adapted to suit the flow and relevance of the topic being discussed. However, Cohen et al. (2018) highlight that the variation of the interviews can be an issue as each individual and group may emerge in different directions. For this research, we were seeking to understand the experience and embodied knowing of the groups and individuals and the process of conversational interviews was best suited to this. Something that occurred within the research process and driven by the participants was the preference for the interviews to be held over Zoom; they were all recorded and transcribed with the permission of the participants. The process using Zoom was simple as participants were used to using this platform and they reported it provided flexibility for them to participate, at times and locations that were suitable to them (Archibald et al. 2019). This is supported in the literature by Cohen et al. (2018) about the advantages of online interviews.

Research Information Collection Journey

The research information collection journey for this PhD research occurred over two academic sessions within the Bachelor of Nursing at Wollongong University (UOW), culminating in a total information collection time of 7 months, July 2019 to February 2020. An academic session in Australia is a 10-week biannual period of learning at UOW, with an additional 10-day clinical placement. We have an Autumn Session starting in February, and Spring Session starting in July each year. The journey embedded into the PhD research consisted of two parts, part one having two rounds and part two had one round only. At each part of the journey, two groups were recruited separately and ran simultaneously, group one a student group and group two a clinical supervisor group. This chapter is focussing only on part one of the PhD journey.

Below is an image (see Image 8-6) that depicts the three steps in the research information collection journey followed by a detailed description of each step:

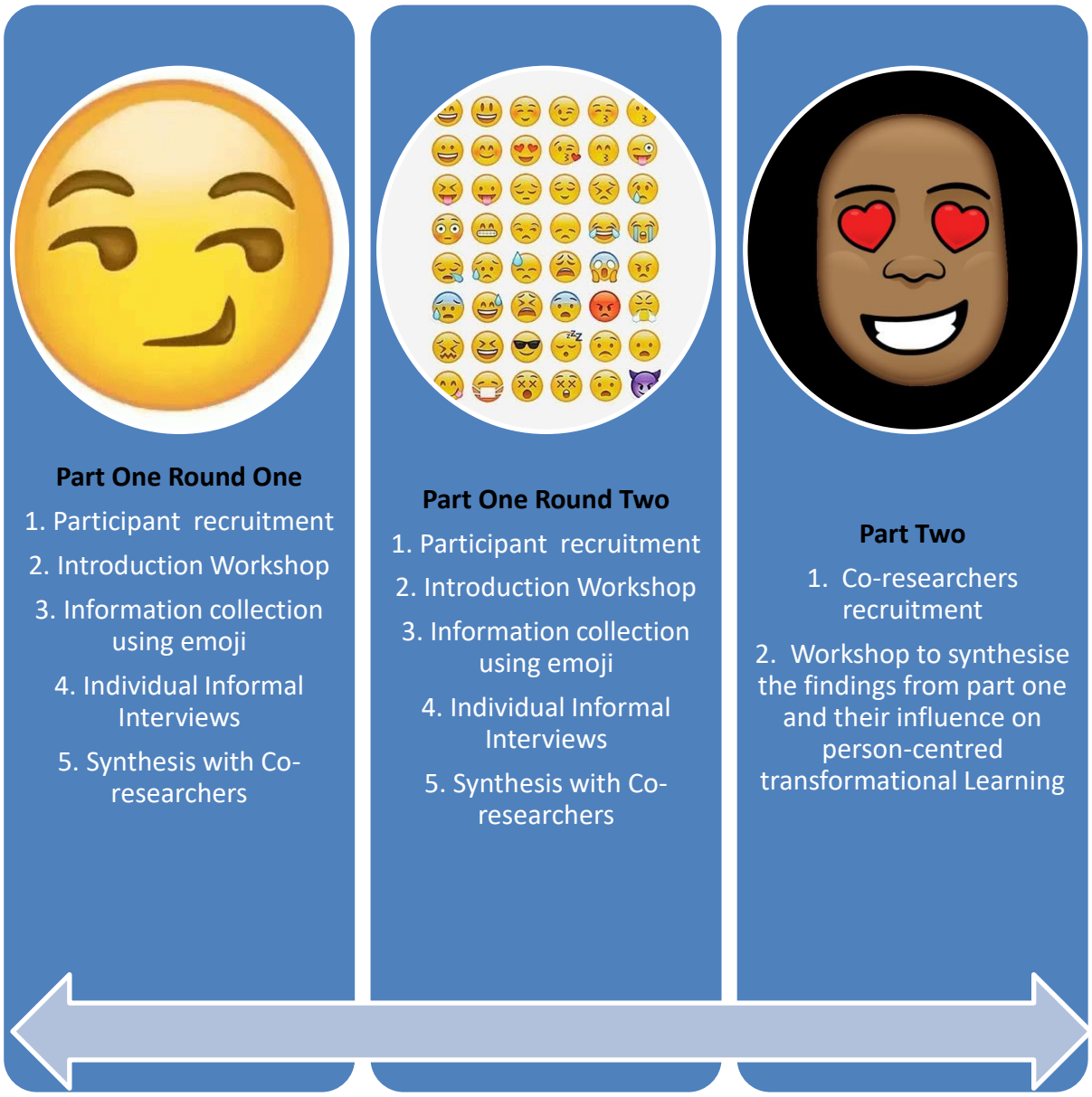


Image 8-6 Research Information Collection Journey (2020)

In the Methodological Model developed within this PhD research (see Chapter 7), I have defined three types of learners: students, clinical supervisors and academic staff. All three undertook the process of information collection in part one together and all have much to learn within the process of this research being undertaken. I have situated

myself in this PhD research as the principal researcher who sits in the third space, which is described in detail later in Chapter 9. I have consciously chosen not to place myself as an insider or outsider but rather as a participant who finds the space within the research in a right way for both me as a researcher and the persons who are participating (Kerr and Sturm 2019). I believe that just as we all have the right to determine our own personhood, we have the right to participate in research in a way that fits with our values and beliefs. I did not want to squeeze myself into a role, as I am neither a student nor a clinical supervisor. I was the principal researcher who was committed to involving the participants within this research in an authentic way, actively participating alongside the participants.

Participants

Participants for the research information collection journey were recruited simultaneously but separately for each step, in part one. Recruitment occurred at the beginning of each round (see Image 8-7) below. The image below shows three recruitment points for each of the groups (students and clinical supervisors), with the criteria for each group also included. This chapter is concerned with the two rounds in part one, part two is reported on in Chapter 9. I aimed for 6-10 participants in each group, this is consistent with the principles of person-centred research where the emphasis is on the relationship with others. Furthermore, this participant number enables us all to grow by being exposed to the learnings of one another (Jacobs et al. 2017). This PhD research sought to identify the two groups' individual perspectives separately and to learn from their experiences. As a reminder, this research is situated within a critical realist paradigm with the intent of informing the future practice of the context this research is being conducted within, rather than seeking saturation or generalisability. It is expected there will be learnings that will inform future practice within academic nursing and other professional based academic contexts with particular emphasis on facilitating learning in clinical practice or learning in non-classroom settings.

For part one, eligibility for recruitment was dependant on the student being enrolled in a Year 1, clinical placement subject (SNUG104 or SNUG108) and the pattern (A, B or C) they were allocated to attend their clinical placement in (see Image 8-7). For clinical supervisors, recruitment was dependant on their employment as a casual clinical academic and their allocation for work in the subject (SNUG104 or SNUG108) for student supervision. That resulted in the recruitment of two groups of students and two groups of clinical supervisors who participated in part one. The UOW Bachelor of Nursing Curriculum has three opportunities for students to undertake a 10-day clinical placement. The first pattern A occurs directly after the 10-week teaching session and before the exam period, then pattern B occurs directly at the end of exam weeks followed by pattern C. The UOW SN Calendar has been attached for your reference (see Appendix I). There were no set exclusion criteria for either group apart from them being Year 1 students enrolled in a clinical placement subject or clinical supervisors employed by UOW to supervise students in practice for these subjects. For the student, the exclusion is their pattern allocation, that is, students in a pattern not occurring at the time of recruitment would not be eligible to participate. For the clinical supervisors, exclusion for them is not being allocated to supervise students in a pattern at the time of recruitment.

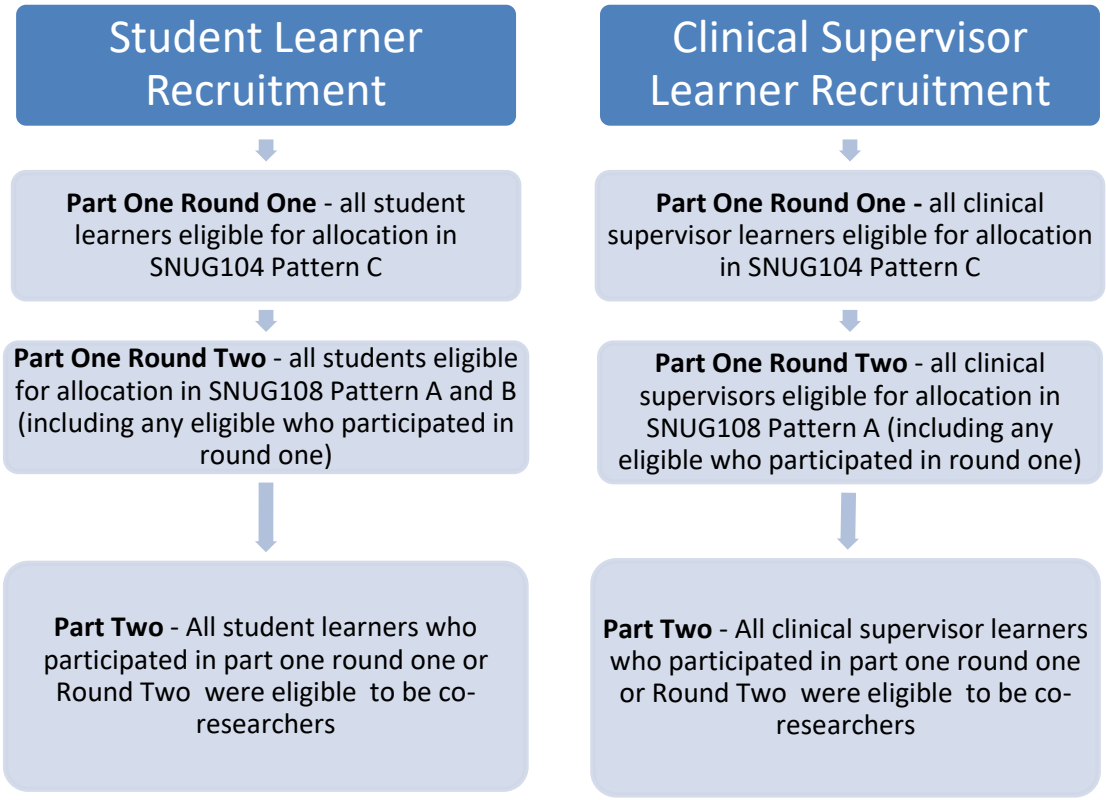


Image 8-7 Participant Recruitment Process

Participants were all provided with a copy of the Participant Information Sheet (see Appendix J) and Consent Form (see Appendix K) as part of the recruitment process. All participants were required to complete the consent form before attending the introduction workshop.

Introduction workshop

The introduction workshop was held at the start of each of the two rounds in part one. I had stated this workshop was to be face to face, however, due to travel distances and competing family and work commitments, both groups requested meetings to be delivered via Zoom (Archibald et al. 2019). The outcome was highly successful, and I did not perceive there was any disadvantage in this change with the participants also reporting that the flexibility in meeting their needs enabled them to participate.

Methods used within the workshops included the use of Dadirri, creating ways of working, critical dialogue critical reflection (Mezirow 1990) and informal

conversation group interview (Cohen et al. 2018). The workshop was conducted as a group interview with a structure in the form of an outline (see Appendix L), that supported the development of critical dialogue and critical reflection (Habermas 1987; Mezirow 1990). The structure was the same for all introduction workshops however, there was flexibility in the conversation enabling the workshops to be responsive to the direction of the participant conversation. To begin the workshop, we read the Dadirri poem and took a few minutes for silent contemplation to enable us to take time to be present in the moment and prepare ourselves for inner deep listening and quiet still awareness (Ungunmerr 1988). Consistent with the person-centred research process, participants in the group were introduced to each other and the researcher using evoke or virtues cards. The purpose of the card was to give each person a talking point to share what they value about being in practice as a student or clinical supervisor. The PhD research topic and question were then presented to the participants with an overview of the research aims and objectives.

Following the introduction, we established our ways of working using the Critical Allies Framework (Hardiman and Dewing 2019) with an emphasis on the pre-requisites of shared values, preparedness, mutual respect and authentic presence. Understanding each other, our values and agreeing our ways of working was established to create a space/condition whereby learning was facilitated, and people could participate in the workshop and consider their role in the research in an authentic way (McCormack et al. 2017; Hardiman and Dewing 2019).

The participants then considered what they understood as healthful relationships between students and clinical supervisors using creativity and cards. They were given time to consider this with the option of expression by using drawing, painting or the use of card or pictures. We shared the words and created a Wordle to creatively document the ideas and their importance to the co-researchers. The Wordle was used in this part of the research to bring together the individual thoughts of each participant and to visually represent for each group, their shared understanding and commonalities for the term healthful relationships. The words that were most commonly used come up the largest and boldest, providing us with a visual representation to critically reflect

on and engage in a critical dialogue (Mezirow 1990) in exploring the concept of healthful relationships. We concluded the workshop with an overview of the information collection process. Each of the workshops were recorded and the transcription formed part of the information collected for this PhD research.

Information collection using emoji

The methods used in this part of information collection were Dadirri as contemplation (Ungunmerr 1988) and emoji (Bai et al. 2019). The participants all undertook a 10-day clinical placement. Following the introduction workshop, they were provided with an electronic version of their emoji information collection sheets (see Appendix M). They were given a sheet for each of the 10-days and this included a copy of the emoji sticker sheet and space to record examples from their practice. They were asked to take 5 to 10 minutes at end of each day of their clinical placement and to take a few minutes to contemplate their supervisory relationship; it was suggested that reading part of the Dadirri poem may help with this (Ungunmerr 1988). After a period of contemplation, they then chose one emoji that represented a positive aspect, and one that represented a challenging aspect of their relationship. The participants in round one did not have a section on the document for examples, however, from the participant feedback after round one, this was included for round two and the participants were encouraged to document examples each day to share later in their information interviews.

Individual informal conversation interviews

Following the completion of each of the clinical placement periods, each participant was contacted via email and invited to attend an informal conversation interview at a time suitable for them (Cohen et al. 2018). The informal conversation interview began with a conversation to explain the process. This was followed by a conversation where the participant shared their experience of their supervisory relationship. The process for this was to be undertaken in order from day 1 to day 10, and the participants were encouraged to share examples of the positive and challenging aspects of their supervisory relationship. All interviews were completed by myself as the principal researcher. The conversation was free-flowing. I only intervened when the participants moved away from their supervisory relationship to a point where they reflected on

their activities within the placement and were not inclusive of their supervisory relationship (Cohen et al. 2018). All interviews were recorded and transcribed so as they could be part of the information collected and synthesised.

I am now going to move through the two rounds and share what was found and my reflection of the research process. Round one is titled beginning to listen and wait with patience and round two is titled learning patience and not to worry.

Beginning to Listen and Wait with Patience

Image 8-8 Part One, Round One Research Information Collection

Overview

In this section of the chapter, I present the actual journey and methods that have been used in round one - Beginning to listen and wait with patience of the PhD journey (see Image 8-8). Within the Dadirri poem, Ungunmerr (1988) shares with us the concepts of listening and waiting. She talks about inner deep listening requiring a sense of contemplation and also highlights the importance that 'the right people must be present' and 'careful preparations must be made'. I sensed this was an important part of being a person-centred researcher, ensuring preparations are carefully made and the right people being present. I believe this is part of the challenge and discomfort of person-centred research, having the patience to trust that the research process will

reveal what it needs to when the time is right. This is the reason why I have referred to this part of the journey as Beginning to listen and wait with patience. The journey included the recruitment of participants, their participation in an introductory workshop, collecting information using the emoji collection sheet, and individual informal conversation interviews (Cohen et al. 2018). These stages within the research process are described in detail above. The synthesis with participant workshop for this round of the research is reported in Chapter 9 as this forms part of the participant synthesis section. I have included my learnings through reflexivity at the end of this section to share my thoughts and feelings regarding this round of the research process.

The timeline for this round of this research process is represented below (see Image 8-9). The round began on 3 July and was concluded on 9 August.

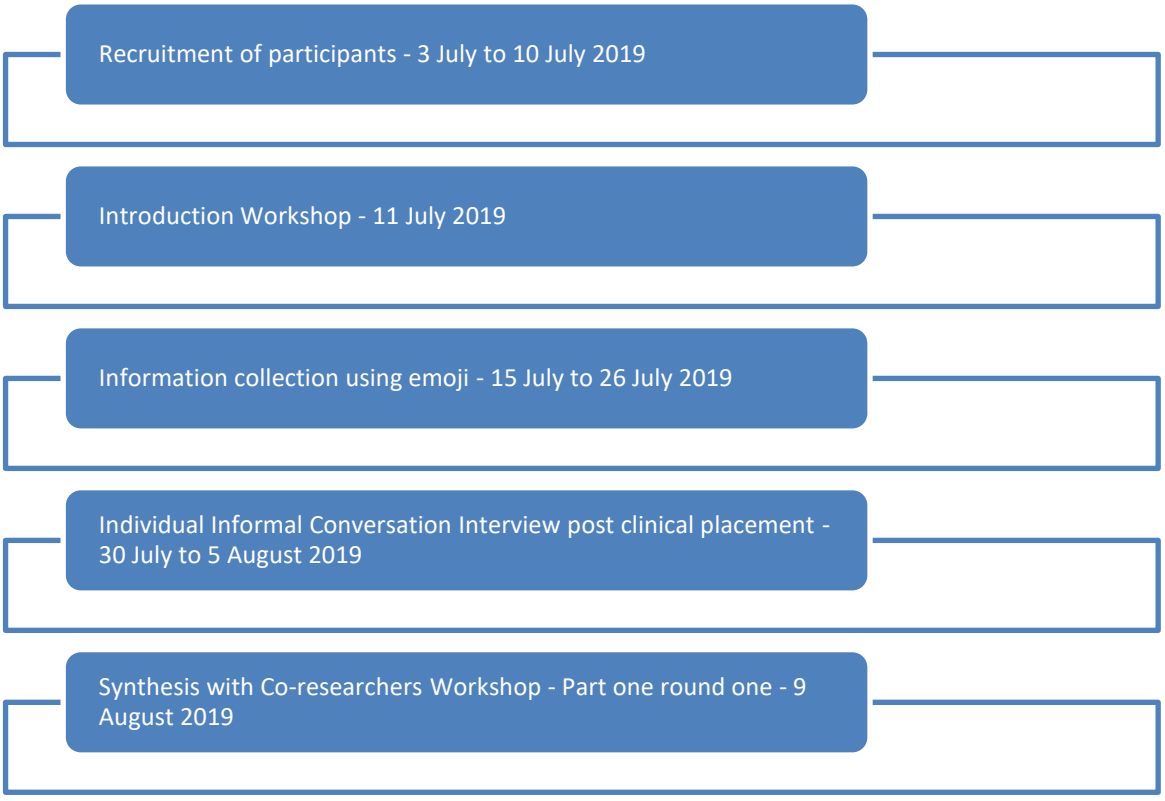


Image 8-9 Part One Timeline, Part One Round One

Participant recruitment

Eligible participants in this research were those students and clinical supervisors who were allocated to a pattern C placement. The recruitment stage for round one commenced as soon as ethical approval was received in July 2019 and finished seven days later, on 10 July 2020, before the commencement of the clinical placement on 15 July 2019. In accordance with the ethics application, the email invitation was sent by a colleague in her role as Subject Coordinator of SNUG104 with the Information Sheet (see Appendix J) and the Consent Form attached (see Appendix K). All eligible participants for both groups, the students and clinical supervisors were sent an email for recruitment to the PhD research (see Appendix N) via their UOW email address as per the research protocol (see Appendix P). Recruitment was conducted from those allocated to pattern C in the subject SNUG104, Workplace Experience 1. Pattern C was the only available pattern once the research ethics procedures were confirmed.

I underestimated the time taken for ethics approval across two institutions and consequently, this created research timeline issues. For example, delays were associated with having to navigate ethics requirements across two vastly different academic university institutions (QMU, Scotland and the UOW, Australia) and resulted in a short timeframe for recruitment to occur. As a result of the delays, recruitment of eligible participants for the PhD research could only be drawn from a total number of 68 students and six clinical supervisors, with the actual number of people who agreed to participate being four students and five clinical supervisors. Pattern C had the least number of students and clinical supervisors allocated, as the SN attempts to have as many students complete their clinical placement in patterns A and B to allow academic timelines such as the declaration of student grades. Students are allocated to pattern C for one of two reasons, it is either a request by the student due to other competing demands or that they have been late in meeting the mandatory requirements for placement, such as immunisations and criminal record check.

Reflecting on my learnings as a person-centred researcher, I revisited the principles I had established for being a person-centred researcher from an ontological (see Chapter 3), personhood (see Chapter 4), philosophical (see Chapter 6), and methodological (see

Chapter 7) perspective. I felt I had congruence in how I saw and understood the world and how this aligned with the approach for this PhD research. Starting the research information collection journey and coming to recruitment was the first time I really had to trust the research process, hoping that the universe would provide for me enough participants to undertake this research. I felt very vulnerable and although I know I held power in this process, at this point I felt powerless as a researcher. I did wonder if this is normal in the research generally, but more pronounced as a person-centred researcher, as I authentically needed to trust that my participants would reveal the gems from their experience in how we understand creating healthful relationships. The struggle to acquire participants who were interested in taking this PhD research with me had fed my fears and created doubt. To manage my feelings of vulnerability, I went back to my methodological principles and re-read Chapter 7; this assured me that the universe would provide, and it did. The overall numbers were less than I initially hoped, but the information collected during the information collection journey proved to be extraordinarily rich.

Introduction workshop

Introduction workshops (one for students and a separate one for clinical supervisors) were both held on 11 July 2019 and were undertaken via the Zoom electronic meeting platform (Archibald et al. 2019), as I had already established that participants preferred this over a face-to-face workshop. The introduction workshops in the format of Zoom meetings were audio-recorded with consent. The transcription of this meeting formed the information that was synthesised.

We started the workshop as described above with a welcome and the establishment of ways of working and then considered what a healthful relationship was from their perspective. I did not contribute to this as I am neither a student nor a clinical supervisor. The Wordles (see Image 8-10 and Image 8-11) below represent the collective understanding each group shared.

Image 8-10 Student Perception of a Healthful Relationship (Round One) (2019)

Image 8-11 Clinical Supervisor Perception of a Healthful Relationship (Round One) (2019)

The words associated with their perceptions as identified in the images (see Image 8-10 and Image 8-11) above form part of the information collected on what constitutes a healthful relationship between students and their supervisors. In comparing the Wordles, the students were more consistent in their ideas compared to supervisors who had a breadth of ideas. These were added to the second round of information collection to form an overall perspective from both the student and clinical supervisors' groups

separately and then as a collective group. Consideration of the similarities and differences were synthesised and reported in Chapters 9 and 10.

The Zoom meetings concluded with an overview of why we were going to use emoji to collect information and as an information collection tool. All participants evaluated the meeting by sharing an emoji from the same sticker page they would use with their information collection sheet to describe how they were feeling about collecting information during their clinical placement.

Information collection

Participants in both groups were provided with an information collection sheet that had 2 separate sections for each day of a 10-day clinical placement (see Appendix M). This clinical placement commenced on 15 July and was completed on 26 July 2019. The participants were asked to contemplate using the concept of Dadirri, deep listening and quiet still awareness, at the end of each shift of their clinical placement and to circle an emoji that represents one positive and one challenging emotion related to their supervisory relationship that day. The emoji information collection sheet was to be considered at the individual informal conversation interview scheduled for each participant and myself (Cohen et al. 2018).

Interviews following information collection

All participants nominated a time that was convenient for them to undertake an individual information conversation interview (Cohen et al. 2018). The interviews were again completed using Zoom. Interviews took place at a time that was agreed with each participant via a Doodle Poll over a timeframe of 30 July to 5 August 2019. For each interview, participants reviewed the information they collected during their clinical placement by reflecting on the emoji they chose each day and described the memories that were made within the clinical placement regarding their supervisory relationship. Each participant had the opportunity to discuss with myself, the researcher, examples from their experiences, and explain their rationale for how and why they selected each emoji. Each individual interview session always started with why the participant chose the positive emoji and then moved to discuss the challenging

emoji. All interviews were audio-recorded and transcribed by me. The analysis of these transcriptions will occur in the information synthesis and discussion phase of this thesis. It was suggested by one of the clinical supervisors that it was useful for them to have notes and examples from their practice, she recommended that we include this idea on the information collection sheet; this was subsequently adopted and we updated the sheet for the next round of information collection.

My learning from beginning to listen and wait with patience

Following groups of interviews, I reflected on how I was feeling as the researcher collecting the information using creativity that included painting (see Image 8-12). When considering my learnings from both the students and clinical supervisors, I have used the term 'gems'. When used within this context, I am referring to the gems of wisdom and insight as shared from their personal experiences and perspectives. It is these gems that shine and help me as a researcher to better understand how students and clinical supervisors experience their relationships in the context of practice.

Image 8-12 Researcher Reflections Following the Student Interviews July/August 2019

As I was participating in the student's interviews, my feelings led me to believe that the participants were speaking about some beautiful gems and that the process of using emoji to elicit emotions was proving to be powerful as an information collecting tool.

The initial painting (see Image 8-12) above was undertaken after the first two interviews and shows the yellow dots as my emotions were shared, whereas lines represent that I was not sure what this meant. My learning from this as a person-centred researcher was that I need to show my vulnerability as the information that was being shared. The purple squiggle should be whatever the student believes it to be. The second picture (see Image 8-12) above represents that the information I was hearing was rich and I needed to have confidence and faith to trust the gems that were forthcoming from the co-researchers as well as be patient as these would emerge when the time was right throughout the PhD journey.

Image 8-13 Researcher Reflections following Clinical Supervisor Interviews July/August 2019

I also undertook reflection following the supervisor's individual information conversation interviews as I had undertaken following the student interviews (Image 8-13). I reflected at the end of each day to ensure I captured the meaning 'in the moment' (Cohen et al. 2018). My initial thoughts are shared here in this chapter and my growth as a person-centred researcher is shared within the Reflexivity Chapter 11. The initial painting in Image 8-13 above was undertaken following the clinical supervisor interviews and portrays what was similar yet different to the feelings that I had following the student interviews. The tree trunk represented the solid foundation

of information shared and I felt that I needed to trust that this would become clear through the analytical process. I felt that the sun was trying to shine and show beams through the clouds; however, the sun was shaded and not completely visible at the time of this reflection.

The second painting followed an interview where examples were documented and shared; this provided rich information where gems became clear to me, as represented in the dots. Participants shared their emotions in depth. I felt the issues of vulnerability as a person-centred researcher emerge again and I feared the information collected may not be enough, yet I needed to have confidence and trust persons' shared experiences as an integral part of person-centred research. On one hand, I believed that people had within them what they need and on the other, I was full of doubt about whether I would obtain rich and meaningful information. I became comfortable living with this discomfort (Fay 1987). I again revisited my methodological principles (see Chapter 7) and held on to my belief that persons are experts in their own journey. I have extended this also in the reflexivity chapter (see Chapter 11).

Learning Patience and Not to Worry

Image 8-14 Part One, Round One Research Information Collection

Overview

In this section of the chapter, I present an overview of the research process in the second round of part one, titled Learning patience and not to worry (see Image 8-14). Continuing the theme of Dadirri in the PhD research, I have included the concept of patience and waiting and learning not to worry. Ungunmerr (1988), in her poem, shares 'We don't worry. We know that in time and in the Spirit of Dadirri …the way will be made clear". Undertaking person-centred research requires every person involved to trust that the way will be made clear, in working together, sharing our inner knowing we will be able to learn together and be authentic to the research; to be "alive and strong". In line with ethical approval, this part of the PhD research was synthesising the information collected in the second round of part one of the information collection.

These students were in their second academic session, undertaking a second clinical placement subject, SNUG108 Workplace Experience 2, as part of their Bachelor of Nursing Program. The research process for both groups (students and clinical supervisors) again occurred simultaneously. This process included the recruitment of participants, their subsequent participation in an introduction workshop, collecting information using emoji during their clinical placement, an individual informal conversation interview (Cohen et al. 2018). As in round one, the synthesis by participants workshop is reported on in Chapter 9. After each of the workshops and interview rounds, I again drew on creativity and reflection to explore my thoughts and feelings (Dewing et al. 2014; Mezirow 1990).

The research process that was followed in Learning patience and not to worry was the same as for round one and is summarised in the (see Image 8-14) above. The timeline for this round of this research process is represented below (see Image 8-15). The round began on 3 July and was concluded on 9 August 2019.

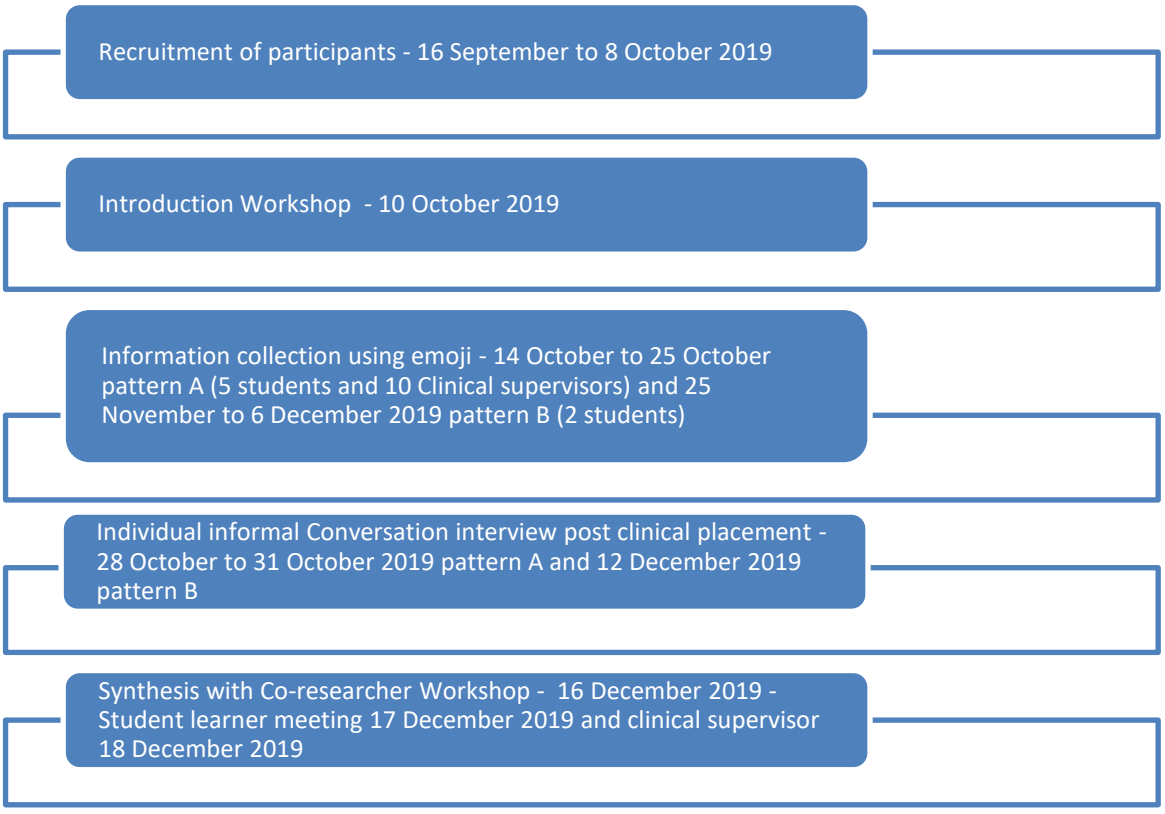


Image 8-15 Part One Timeline, Part One Round Two

Participant recruitment

Recruitment of participants was conducted from 16 September 2019 to 8 October 2019. The process was the same as described in the previous round. Recruitment was conducted from those students and clinical supervisors allocated to patterns A and B in the subject SNUG108, Workplace Experience 2 (see SN Calendar –Appendix I). The later pattern C students were not invited to participate as they were not allocated a clinical placement in the timeframe for the information collection. The pattern C placement was scheduled for after the exam period and was being completed just before the Christmas break which did not allow time for interviews post-placement. All eligible students and clinical supervisors were sent an invitation regardless of whether they participated in round one.

The response from the clinical supervisors was incredibly positive and timely. Interested persons were excited for the opportunity to be able to participate and followed up quickly with positive responses. Alternatively, the student group response was slower than I expected, culminating in low numbers of responses. Several students did respond to say they would like to be involved although un with their placement allocated at the end of the session, the time pressures of a ten-day placement, and their exams being only two weeks later they were not able to participate. The issue of the timing of the placement being so close to the end of session and exams was something I had previously considered, however, given the curriculum design there was nothing that could be adjusted to allow for changes to the timeline for the research as students were required to collect information using emoji during their placement period. I felt the students' anxiety in their declined responses, and my own level of anxiety, that I may not have enough responses to complete this round of the research from the student group.

For the student group, there was a potential recruitment pool of 371 students (264 in pattern A and 107 in pattern B) and 26 clinical supervisors who were employed as UOW Casual Academic Staff and allocated to students in either pattern A or B. The actual number of people who agreed to participate were seven students (all of whom

had not participated in round one) and ten clinical supervisors (two of whom had participated in round one, with eight new participants). Ten students initially responded to participate, however, three withdrew as they were not able to attend the initial workshop one for this round. The participants in round two were then allocated to their respective groups for all activities within the research process, where the students were in group one and group two was the clinical supervisors.

Again, this recruitment process was the most challenging for me in the overall research process. My hope that I would attract enough participants to ensure the information collected was meaningful, preoccupying my thoughts. I drew on the contemplative way of Dadirri to ensure that I exercised patience and learned not to worry. I was concerned that if I internally worried about recruitment and lacked trust in the research process, this would become visible to the persons who had agreed to participate. I used the message from the Dadirri poem that shares with us that struggle and the long waiting enables learning and a better understanding. I checked in and shared my concerns with the people who have supported me locally in this research process and who were undertaking recruitment. This dialogue with others assisted me to develop positive strategies to manage my vulnerability and anxiety. I again revisited my methodological principles and reminded myself to trust the process.

Introduction workshop

Both introduction workshops were held on 10 October 2019 for one hour; an outline of the workshop is available in (Appendix L). The next step of the research process was for all participants to meet in their two separate groups with myself as the lead researcher and another academic from the UOW. This process was the same as had occurred in part one round one, again ensuring due process in accordance with the approved ethics application. As with the previous round, the meetings were undertaken via the Zoom electronic meeting platform (Archibald et al. 2019), as participants preferred this over a face-to-face workshop. These workshops were therefore a Zoom meeting which was audio-recorded and transcribed. Notably, the process followed was a replica of round one to ensure that the information provided was consistent and that the collection of emoji and analysis of this round followed the same process.

The workshop started with the introduction and establishment of ways of working with the participants. Participants then considered what words would describe a healthful relationship between students and supervisors. These words were again placed into a Wordle (see Image 8-16 and

Image 8-17) recording their ideas and representing those words which were more commonly suggested. These appear as the largest and boldest in the images below:

Image 8-16 Student Perception of a Healthful Relationship (Round Two) (2019)

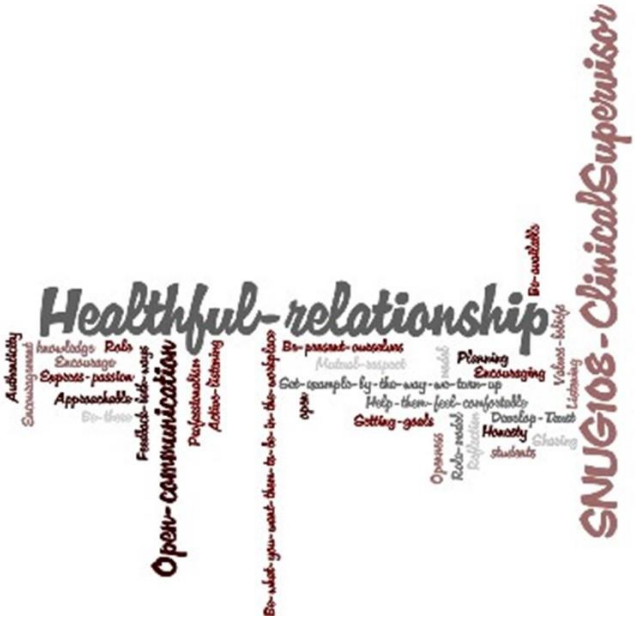


Image 8-17 Clinical Supervisor Perception of a Healthful Relationship (Round Two) (2019)

Information collection

The information collection was undertaken from 14 October to 25 October for pattern A (5 students and 10 clinical supervisors) and 25 November to 6 December 2019 for pattern B (2 students). Again, as per the ethics protocol, this round of information collection was a replica of round one. Each participant collected their positive and challenging experiences using emoji during placement. Participants in both groups were provided with an information collection sheet for each day of the 10-day placement (see Appendix M). From the recommendation of previous participants, a new section was added to the information collection form. Learnings from part one round one were shared with the co-researchers in the second 'synthesis with co-researcher workshop' and changes were incorporated into the process for information collection for each day to provide an example of positive and challenging situations in the supervisory relationship. Previous participants reported that having documented examples helped them with their responses at the post-placement interview.

The participants were asked to undertake contemplation using Dadirri, deep listening and quiet still awareness at the end of each shift of their clinical placement and circle an emoji that represents one positive and one challenging emotion related to their supervisory relationship (Ungunmerr 1988). In addition, for this round, participants were asked to write a brief example of the positive or challenging experience to assist with their memory recollection at their interview that would take place after the completion of their 10-day placement.

Interviews following information collection

Individual informal conversation interviews (Cohen et al. 2018) were conducted over a timeframe of 28 October to 31 October 2019 for pattern A and 12 December 2019 for pattern B. All participants nominated a time that was convenient for them to undertake an individual interview. The interviews again used Zoom and were recorded for the purpose of transcription. For each interview, participants reviewed the information they collected during their clinical placement by reflecting on the emoji they chose each day and to describe the memories that were made within the clinical placement regarding their supervisory relationship. Each participant had the

opportunity to discuss examples from their experiences and to explain how and why they selected each emoji. To commence the individual information conversation interview, participants were encouraged to go over each day separately by sharing the positive and then the challenging emoji they selected. This was encouraged to start the conversation about each day on the positive aspect of the relationship. All interviews were audio-recorded and transcribed.

Securing the times for the clinical supervisors was a streamlined process where they responded quickly, and times were organised. The clinical supervisors all attended their scheduled interviews with only one participant needing to be rescheduled due to family issues. The students were at a stage where they had completed their learning for the academic session, and they were in preparation for exams. They worked more hours to meet university commitments, attend tutorials, and complete clinical placement, and I found they required multiple follow-up messages with several interviews requiring rescheduling. I found myself feeling worried and anxious that not only would I not achieve all interviews being completed but also that I may have placed additional stress on the students at a time when they were busy and preoccupied with their exams and their need to increase their income during what they perceived as out of session time. On reflection, I believe that I assumed that as their exams were in the next few weeks they would not commit heavily to work and would remain engaged in their studies, however, this was not the case, and all communication I had with students regarding their challenge to commit to the interviews was work related. After I practised learning patience and not to worry on both sides, all 7 students managed to complete the interviews. Interestingly, in the feedback from the students who participated, two reported that I was patient with them and the process, appreciating this as they wanted to be part of the research, but just needed to wait for the time to be right.

My learning from learning patience and not to worry

Following all interviews for each group, I reflected on how I was feeling as the researcher, collecting the information, using creativity and drawings (Image 8-18). I was conscious not to analyse what I heard in the interviews, as the participant groups were going to do this in the analysis workshops.

Image 8-18 Researcher Reflections Following the Student Interviews, Round One Part Two October and December 2019

I undertook the student interviews across two time periods. I spent time reflecting after the groups of interviews and I drew the pictures above at different times. After the final four interviews, the first picture was drawn after the initial three interviews and the second one. The first picture represents that I had heard so much wisdom from these students and felt love and was immensely proud. I heard that for them, things within the relationship are either there or they are not, it sounded black and white. I represented this in colour, which is separated with the jagged line, as the richness of their information was colourful. I heard that students felt disempowered, needing trust, respect, support and to be nurtured. Although this was in some way expected, coming from them in an articulated and heart-felt way through the exploration of their relationships using emoji, made me feel so proud of their insight into their own learning needs.

In the second picture (see Image 8-18), I again used the heart to represent the respect I had for their wisdom in sharing their experiences with me. However, this time the two emoji faces represented the students who wanted to have a supportive, kind clinical supervisor. Interestingly, they talked about wanting this amazing clinical supervisor, however, they only wanted to see them when they needed them and not all the time. They talked about finding it overwhelming when their clinical supervisor was there when they perceived they did not need them, and I found that fascinating. The interesting aspect of this was the impact on their relationship and they shared this with what I felt was openness and honesty. I found myself wanting to ask more questions about this, but again ensured I was there showing patience and as a listener, not as an interrogator for information that was not overtly shared.

Image 8-19 Researcher Reflections Following the Clinical Supervisor Interviews, Round One Part Two (October 2019)

I undertook the same reflection process following the supervisors' Zoom meetings as I had undertaken following the students' interviews in round one. I reflected again on two separate occasions following groups of interviews. The first drawing in the image above (see Image 8-19), represented my self-reflection in the interviews, that I did not hear in round one. It became clear to me that emoji's use during their supervising students' practice the clinical supervisors became more aware of their role to create

relationships with students. They expressed that exploring their feelings made them more aware of the students' feelings. The second drawing in the image (see Image 8-19) raised my awareness about comments being made by clinical supervisors with regard to them feeling frustrated with situations, and the impact of student behaviours. I was intrigued by their perception, that they could hide their frustrations from the students, yet believe they were being authentic. Interestingly, they recognised that they felt happy in themselves when students were happy, but during our interviews had no awareness that students would perceive or sense their frustrations.

I felt at this point I was becoming more comfortable with the discomfort of being a person-centred researcher. I felt that the process was working and then I began to wonder if this was about my presence being more comfortable or the persons who were participating. I decided this was a combination of all factors and that it was acceptable to feel this sense of awe and wonder at what I heard and how this made me feel. I was aware it was short lived and that moving forward with the research journey would again challenge all of us to a point of discomfort and ethically and we would learn from that in ways we did not imagine or expect.

With part one coming to an end, I was feeling both excited and anxious about moving to the final synthesis for part one as the reality was all information was now collected. Ethical considerations are now explored below. They are situated here in the thesis as I was able to share two parts. Firstly, the ethics application process but also the ethical issues that have arisen in part one.

Ethical Considerations

This section of the chapter provides an overview of the ethical considerations for this PhD research. The ethical considerations for person-centred participatory research are more than the process of gaining ethical approval through an ethics committee. This chapter starts with the ethics approval process and then moves to the broader ethical considerations. The ethics approval process is important to ensure no harm is done to persons in the course of the research. I sought and gained ethical approval from Queen Margaret University, Edinburgh, the university where I was enrolled as a PhD student

and the University of Wollongong, Australia, HREC 2019/237 (see Appendix Q), where I was employed, and the setting for the research. As part of the ethics approval process, I worked within a risk analysis model. In assessing and mitigating risk, I identified two potential risks. The first being the risk of emotional stress to participants as co-researchers who reflected on their relationships with others. To mitigate this there were always two academic staff present at each of the workshops, with one being focussed on the safety of individuals and the group. The second risk was confidentiality breaches for data, and this was mitigated with the information for the PhD research being kept only on the password protected QMU or UOW servers. Later in this section, I explore ethical considerations more broadly using Polit and Beck's 2017 (pp. 79-82) "Ethical Principles for Protecting Research Participants."

Haraldsdottir et al. (2019, p.2) have provided an overview of ethical considerations for person-centred research, arguing that:

> The person-centred approach to ethical research, based on an ethic of care, is always relational and situational; whereby choices made are morally based, fully consider the context in which the research takes place and take account of the individual's lived world throughout a study.

Further exploring of ethical considerations and being true to the person-centred participatory nature of this research project, I reflected on the experiences of myself as an academic researcher and the participants using Polit and Beck's (2017) interpretations of the ethical principles within the Belmont Report: beneficence, respect for human dignity and justice. I chose this framework as I believed it considers the issues of harm to persons participating, respect for human agency and justice which includes fairness for all, aligning well with person-centred research principles.

Beneficence

Researchers have a responsibility to minimise any harm, hoping to provide the participants with an opportunity to benefit from taking the research information collection journey (Polit and Beck 2017). Some of the participants shared that they initially undertook the research to help me, however over time, this became less important to them and they realised they were benefitting by receiving insight into their own practice and their role in creating relationships with others.

1. The Right to Freedom from Harm and Discomfort

The power issues were complex and related to the concept of non-maleficence; in doing no harm to the participants (Polit and Beck 2017). The abuse of power could impact on the safety of the participants and cause harm. I remained mindful that my actions, words, would have an effect on others and was very conscious of being clear in any communication, adhering to the ethical approval received. A serendipitous finding for me was that first-year students appeared to be more willing and able to challenge my assumptions as the principal researcher than the experienced registered nurses in the role of clinical supervisors. When I asked the students about this, they responded that they were fee paying students and they felt they had a right to challenge me where clinical supervisors were employees and less likely to challenge. The student group was not surprised at all.

For the clinical supervisors, there was potentially a feeling of pressure to take part in the PhD research, as they were casual academic staff members employed by the university and held an annual contract. However, it is important to stress that their relationship with the principal researcher was not a formal managerial one. I was involved in the recruitment and preparation of clinical supervisors; therefore, it could be wrongly perceived by them that I had an influence over their ongoing employment and some related matters such as their allocation of work.

I do not believe any participants came to physical harm from participating in this research information collection journey. There was some stress related to work, study and family commitments and the January 2020 bushfires in Australia. Several

measures were put in place to reduce any feelings of pressure to participate in the PhD research. As stated earlier in this document, the initial contact for recruitment was an independent person. This independent person (the recruiter) contacted all eligible participants. The recruiter was responsible for sending an email (see Appendix N) to students and clinical supervisors and inviting them to participate, providing them with an overview of the PhD research and the access to further verbal and written information. This strategy removed me from the initial recruitment process.

The ethical issue of beneficence or doing good (Polit and Beck 2017) was relevant here, as participants hopefully gained benefit from participating and therefore continued in the research as they were receiving a benefit. In the individual interviews, participants in both groups reported that the contemplation (Ungunmerr 1988) and reflection on emoji helped them to make more purposeful and meaningful or healthful supervisory relationships and that the reflection using emoji would benefit others if this became part of the practice and the experience of being in practice. I believe this demonstrated a 'doing of good' and was pleased that there was a benefit for those who chose to participate.

However, I do believe that there was discomfort created for the student group as they attempted to navigate the complexity of work, family and studies. As discussed earlier, I feel this was also compounded with the January 2020 bushfires in Australia. I received messages from students in all recruitment rounds that indicated they would like to participate; however, given the complexity of their lives, they were not able to do so. I believe that my responses validated for them that participation was of their own free will and that I fully understood and supported their decisions.

2. The right to protection from exploitation.

The role of the principal researcher and my role as the Director of Clinical Learning and involvement in the allocation of clinical placements for both students and clinical supervisors was explained in the participant information sheet (see Appendix J) and the initial meeting with the participants. The participants had information on how to escalate any concerns to the Principal Supervisor and/or the Graduate Research office

if they felt they were not being addressed or they were uncomfortable with issues or people.

I also had a role as a Subject Co-coordinator for SNUG104 and SNUG108. As I was the co-coordinator of both subjects and the principal researcher within this PhD research, the student participants had their work marked by casual academic staff engaged specifically for marking, and any concerns regarding the marks received were directed to the Deputy Director of Clinical Learning who is the other Co-coordinator for both clinical placement subjects. This information was provided to participants at the introduction workshop and reinforced at each point we met. As these students were in their first year of study, they may have felt an increased sense of pressure to participate; this was addressed by all initial email messages being sent by another academic staff member and them having an independent academic to contact who was also the Academic Program Director for the Bachelor of Nursing; her details were on the Participant Information Sheet (see Appendix J). I only contacted students once they agreed to participate.

Respect for Human Dignity

This is the second principle and includes the "right to self-determination' and the right to full disclosure" (Polit and Beck 2017, p.154).

1. The right to self determination

An issue related to power were my concerns about coercive behaviours in resending messages to participants, as there were times the response to requests for participants to volunteer was slow. I ensured I reflected on my feelings related to this and checked with other academic staff to seek advice and an independent view on the timeframes for resending messages. I believe that being mindful of how and the frequency of correspondence to the potential participants assisted me in recruiting persons who had a genuine interest in being involved with the research.

2. The right to full disclosure

All information collected was validated with the participants who provided it. Consent was gained for all recording and transcriptions. The issue of information being collected using Zoom's online format was something that arose from the way participants chose to participate. It was convenient for them however it also introduced issues with information sharing and collection that I had not prepared for previously. Zoom is an easy platform to share screens and information and this assisted with the collecting and analysing of information.

Justice

Justice is the third principle and has been defined by (Polit and Beck 2017, p.155) as "participant's right to fair treatment and their right to privacy."

1. The right to fair treatment

All people who were involved in the research information collection journey had the capacity to provide their consent. They were all persons who had a high level of literacy and comprehension.

All participants had the option to withdraw from the PhD research at any time. This was outlined in the participant information and consent forms (see Appendix K). The initial meeting with the participants reiterated this in person. There were points throughout the research where participants were invited to consider their ongoing participation in the research and were reminded that they could withdraw from the PhD research at any time. Becoming a co-researcher was offered to all participants at the initial meeting. The time consideration and responsibilities were outlined along with the benefits of being a co-researcher to all participants and they were informed that their commitment to being a co-researcher was an option not a requirement to participate. Three students agreed to participate and withdrew due to work, family and study commitments and the principal researcher supported this.

2. The right to privacy

Only information that is relevant to the purpose of this PhD research was collected.

All participants were informed that information shared by them and collected by the researcher may be disclosed to other co-researchers. Informed consent to record and transcribe any information collected was re-established verbally at the time of the interviews and workshops. Participants were able to withdraw consent from sharing information that is personal to them. The issue of confidentiality formed part of shared ways of working with each group. The only exception where a breach of confidentiality could have occurred was during observation or discussion where information could be disclosed that highlighted issues of concern around risk to the participant or others, or malpractice. As a health professional, I have a duty of care to raise concerns through appropriate channels in the organisation. This was discussed and highlighted to all participants. There were no areas of concern raised during the PhD Research.

I believe all the above ethical considerations fit well with my methodological principles. These include:

Principle 1 Human Flourishing (McCormack and McCance 2017)

- Persons who participate in this research have innately within them the ability to flourish to their full potential both as participants and as co-researchers.

Principle 2 Power within a social relationship (Habermas 1987)

- Persons who participate in this research have the right to authentically participate in this research in the right way for them and maintain the power to change their contribution at any point within the research process.

Principle 3 Courage and Curiosity (Brown 2018)

- Persons who participate in this research have the courage and curiosity to explore the layers of the relationships they develop during a clinical placement, considering how this impacts on their ability to realise human flourishing.

Principle 4 Transformative Learning (Mezirow 2000)

- That all turbulence in clinical practice has the potential to transform into purposeful turbulence enabling student, clinical supervisor and academic staff to realise true belonging and transformative learning.

Principle 5 Contemplation (Ungunmerr 1988)

- That contemplation is embedded into the Knowing, Doing and Being as a participant and co-researcher in this PhD research.

I have been mindful at each step of the research process to revisit these methodological principles, consider my actions and behaviours against these.

Chapter Summary

In summary, I have presented both the methods that were undertaken in the research information collection journey and commenced the journey of developing myself as a person-centred researcher; this is further explored in Chapter 11, My Reflexive Journey as a Person-centred Researcher. I have summarised my thoughts and feelings of this chapter in the poem below. The methods used within this PhD research were developed conjointly with potential participants and myself. Trusting their wisdom resulted in a process that organically enabled the participants to be actively involved in the research process. My journey working through the PhD research methods was full of doubt, fear, and vulnerability. I believe I have collected information that shows great insights and in the following chapters, I share the synthesis with participants in Chapter 9, and the discoveries made through synthesis and meta-synthesis in Chapter 10. I felt a sense of congruence in the consideration of ethical issues, my methodological principle and the approach we collectively participated in to collect information.

Poem

Doubt, fear and vulnerability
Is this normal for a person-centred researcher or am I different?
Journey with rather than journey alone
Participants, co-researchers and practice
Sensing growth in discomfort
Developing creativity through vulnerability
Methods you say, what are they?

Doubt, fear and vulnerability
Wonder, awe and curiosity
Growth in learning together
Seeing others develop and starting to see myself develop
Unearthing gems
Sensing embodied Knowing
Doing Being and Becoming are evident
Methods you say, I think I am starting to get this

Doubt, fear and vulnerability
Starting to make sense and seeing the gems
Reflection and reflexivity
Learning from reflection
Reflecting reflecting reflecting
Learning more about me than about others
Confronting and rewarding
I am happy in my growth and in what I see in others
Developing as persons and person-centred researchers
Methods you say, just as we think we have it, it is now time to move on again

This chapter has critiqued part one of the research process and considered the PhD research's ethical considerations. Travelling along the road to Chapter 9, the synthesis with co-researchers begins in part two of the research process. Chapter 9 justifies the

approach to synthesis that the co-researchers undertook and portrays the voices of the students and clinical supervisors in how they made sense of the information collected in part one.

Chapter 9

The Cobbled Road to Synthesis with Co-Researchers

Image 9-1 The Cobbled Road to Synthesis with Participants and Co-researchers - © Maria Mackay 2020

Introduction

In this chapter, as I wander the cobbled road (see Image 9-1) I present the synthesis of information collected that was undertaken collaboratively with the co-researchers for this PhD research. The chapter begins with an overview and justification of the synthesis process, followed by a detailed discussion of this approach. The next section of the chapter then moves to part two, where all the participants are again invited to be co-researchers and participate in an overall synthesis that brought together the findings from both rounds in part one and considered this against the research question. The final synthesis process considered – How do healthful relationships between students and clinical supervisors influence transformational learning? The chapter concludes with rigour as applied to this PhD research. This is the initial round of synthesis undertaken with the co-researchers and is followed in Chapter 10 by the final synthesis stage where I bring the two groups, students, and clinical supervisor findings together to reveal the PhD's combined discoveries.

The Approach to Synthesis With Co-researchers

In this section of the chapter, I provide an overview and justification for the approach taken to the synthesis of information with co-researchers. I have considered the concept of synthesis rather than analysis as this term is consistent with qualitative research (Polit and Beck 2017). This concept of synthesis is further explored in Chapter 10, where I expand the concept of synthesis and introduce meta-synthesis. Person-centred and creative ways of synthesising the research information collected from the co-researchers' perspective were built into the methods and ethical approval. This approach was suggested by potential participants in the planning meeting (see Chapter 7) and is consistent with participatory person-centred approaches to research where participants are included in all aspects of the research including synthesis (Jacobs et al. 2017). All synthesis workshops were conducted using Zoom. Williams and McCormack (2017) assert that it is important that participation is as easy as possible for participants. Therefore, the co-researchers' preference to use Zoom in the workshops was respected, enabling them to participate virtually in a practical and meaningful way. Consistent with ethical approval requirements, all workshops to undertake the synthesis of information were held separately for each group of participants, one group being students and the other clinical supervisors.

The image (see Image 9-2) below provides a visual depiction of the inclusion of synthesis after each round in part one and part two. The process of synthesis in part one included the co-researchers considering and synthesising the information collected in each round (i.e., part one, round one and round two) and sharing their perspectives. The synthesis also occurred in part two and involved synthesising findings from the previous two rounds in part one together with consideration of the influence of healthful relationships on person-centred transformational learning.

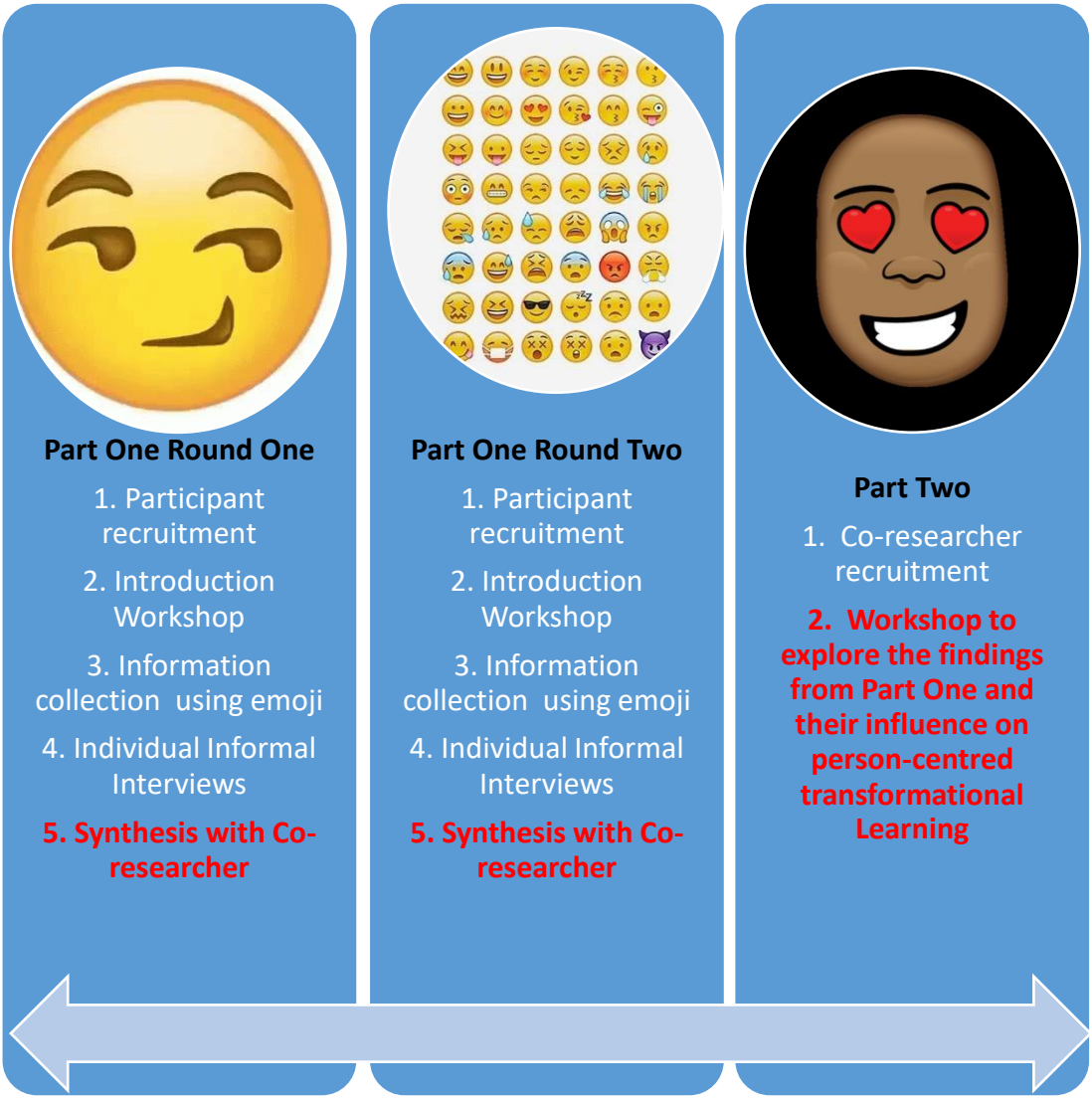


Image 9-2 Research Information Collection Journey (2020)

The image (see Image 9-2) above provides a representation of how synthesis is entwined through the research process. All of the participants who have agreed to participate in this part of the research process are classified as co-researchers. Although all participants were invited to participate in part two, I respect each participants' decision and their right to self-determine the level of participation. I have used a simplified version of the McCormack et al. (2010) approach to synthesis. The aim for the synthesis with the co-researchers is to ensure their individual and collective voices were present thus enabling two unique perspectives (the students and the clinical supervisors) of the research question to be illuminated. The next level of synthesis is

described in Chapter 10, where I, as the principal researcher, use my voice to bring together the students and clinical supervisors' voices.

Synthesis was undertaken with both students and clinical supervisors on separate occasions to interpret the information collected to date in this PhD research. This information came from three main sources, and all sources had the voice of the participants as an integral part of them.

For part one, synthesis was undertaken with co-researchers during workshops, the information collected included:

1. The interview transcripts from each participant in part one, round one and two, (student and clinical supervisor voices).

For part two synthesis was undertaken with co-researchers during workshops, the information collected included:

1. The transcriptions from the introduction workshops in part one, round one and two (student and clinical supervisor voices).
2. The interview transcripts from each participant in part one, round one and two (student and clinical supervisor voices).
3. The transcripts from the co-researcher analysis workshops in part one following round one and round two (student and clinical supervisor voices).

Transcripts were de-identified and shared with the co-researchers prior to the workshops via their secure UOW email. Following the workshops, the co-researchers were contacted to delete the email and all copies of the transcripts. All co-researchers then emailed the principal researchers to confirm that the transcripts had been deleted.

The process that was followed for the synthesis of information in part one and part two follows an approach described by McCormack et al. (2010). This approach for synthesis was congruent with the ideas identified by potential participants from our

initial planning workshop. They expressed the view that creativity should be a key element in making sense of the information collected.

The four steps of synthesis as presented below were completed by the co-researchers in their separate groups (a student and clinical supervisor group) in part one at the end of each round and in part two. The steps for synthesis of information were undertaken to create a shared and comprehensive understanding of the research question.

These four steps are:

1. A naïve read where all identified information was read by the co-researchers. The information included in the rounds in part one and part two is described above.
2. The next step was a synthesis of information. Firstly, this approach was to consider the salient points that stood out for individuals from the information they reviewed, then they considered the information more globally against the research question. Dadirri was used to create an environment for contemplation (Ungunmerr 1988).

   In part one, when considering the meaning of the term healthful relationship, the co-researchers used critical reflection and critical dialogue to synthesise information and (Mezirow' 1990) to create a Wordle at each of the synthesis workshops in part one. We then moved to the transcripts and each co-researcher used creative methods such as painting, drawing or cards individually to critically reflect on their learnings and represent their own interpretation of the information.

   In part two, the co-researchers reviewed the Wordles created from part one and shared following a period of contemplation (Ungunmerr 1988), what was important from them and what may be missing. They then considered how this shared understanding of healthful relationships and the information collected in the 'synthesis with co-researcher workshops' influenced the theoretical framework – Person-centred Transformational Learning in Clinical Practice.
3. The third and most complex step was to 'create a shared and comprehensive understanding or story.

In part one, the co-researchers creative representations came together as a collage and they took time for contemplation using Dadirri (Ungunmerr 1988) to consider 'what did they see, feel and experience' when they contemplated the collage. They shared this with each other and used a Haiku to bring the overall story or shared understanding together.

In part two the co-researchers engaged in critical dialogue to share their thoughts on how healthful relationships influence transformational learning by reviewing the theoretical framework – 'Person-centred Transformational learning in Clinical Practice' and learnings from this were shared.

4. The final step I added to the McCormack et al. (2010) synthesis process is a reflexive process where I completed a creative and written reflection on my role in the synthesis process against my methodological principles. This formed the final dialogue I had myself when I reflected against my methodological principles. Some of this is shared in this chapter and the more detailed reflexive process is shared in Chapter 11.

Synthesis with Co-researchers - Part One

All participants for each of the rounds in part one was sent a recruitment email (see Appendix O) to invite them to participate in the 'synthesis with co-researcher workshop' as a co-researcher. As in the information collection part of this research process, the email was sent by another academic staff member who was not directly involved within the research. The emails were sent via the participants' UOW email address. I will share the numbers of participants who agreed to participate in each round as I describe the workshop and share the findings.

The methods (see Chapter 7) used within the 'synthesis with co-researcher workshop' in part one were the same in both rounds and the workshops mirrored each other. Synthesis of information was undertaken separately in each round (one group was the students and another group was the clinical supervisors). The workshops were conducted as group informal conversation interviews (Cohen et al. 2018) and were underpinned with creativity and included contemplation using Dadirri, critical dialogue and critical reflection as a foundation for creating a shared story (Habermas

1987; Ungunmerr 1988; Mezirow 1990; Dewing et al. 2014). The 'synthesis with co-researcher workshops' occurred as a two-hour workshop. Participants in their separate groups considered the information collected. Dadirri (Ungunmerr 1988) was read and participants were encouraged to take time for contemplation while reviewing the information (transcripts were shared in a secure Dropbox where co-researchers accessed this using their UOW credentials) and to listen deeply to their thoughts and feelings after some deep listening and quiet still awareness. This section of the research was underpinned with creativity where participants individually considered the salient points from the information and shared their interpretation using painting, drawing, cards or words. Once they had completed their individual creative piece of work, they then shared this with others by using 'I see, I feel and I experience' (Dewing et al. 2014). To complete the process, each group agreed on a Haiku and explored their further learning using critical dialogue (Mezirow 1990). All workshops were recorded and transcribed. They formed part of the information collection for part two later in this chapter and the principal researcher synthesis and meta-synthesis described in Chapter 10.

Beginning to Listen and Wait With Patience

The initial 'synthesis with co-researcher workshop' was conducted following the collection of information after the first round in part one. Two separate 'synthesis with co-researcher workshops' were held on 9 August 2019, one for students and one for clinical supervisors. Three students and five clinical supervisors attended their respective workshops. These workshops were again conducted as Zoom meetings as requested by co-researchers. To begin the meeting, I shared my reflections on the interview process with each group's co-researchers. These pictures and a description of my thoughts and feelings are included later in this chapter. I allowed time for co-researchers to raise any questions after this process however no questions were forthcoming from either group.

Student workshop

The three student co-researchers who participated in the workshop to focus on synthesis chose to use painting to represent their individual interpretation of the

interview findings. Their pictures are represented below as a collage (see

Image 9-3) of the student version of 'synthesis with co-researcher workshop'.

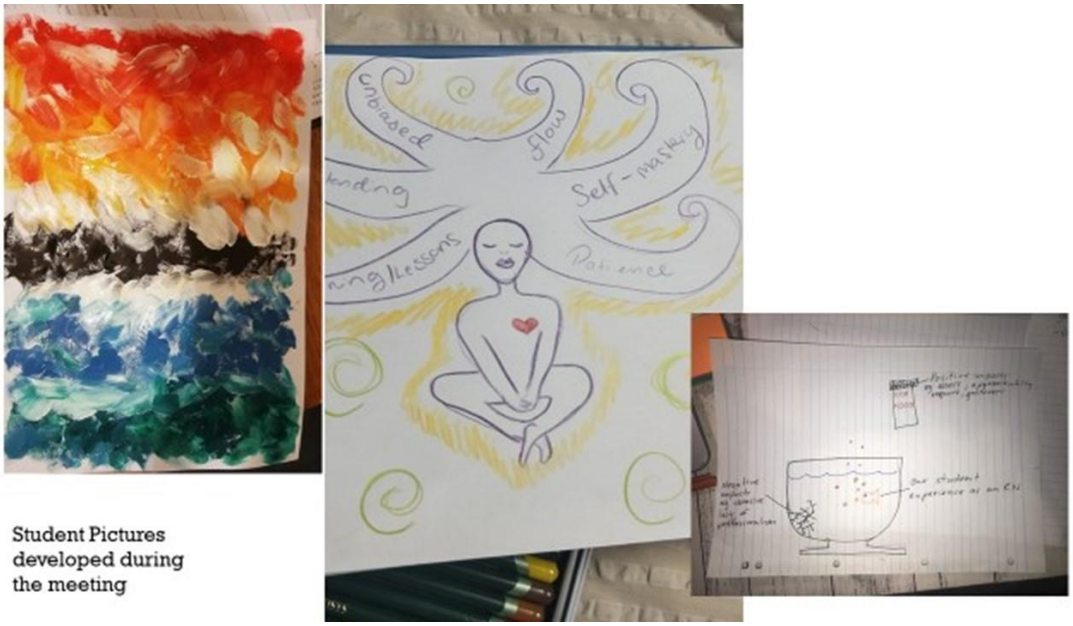


Image 9-3 Synthesis: Student Workshop (2019)

All of the pictures created by the students (see

Image 9-3) were then arranged together and the participants contemplated the memories that were made for them, and described this using the words of I see, I feel and I experience (Dewing et al. 2014).

I see

A fight about what you let your emotions be

Barriers you need to overcome to achieve the placement

I feel

Layered with positive and negative

Conflicts, challenges and positives

Nursing is like a pressure cooker

Up to the individual to be balanced

Use training and stay balanced

I experience

Having a clinical supervisor that is approachable and another who is less approachable is common

Seeing others' interactions impact on me as well

Challenges help to reflect on future practice as a nurse

We have focussed on our inner strengths

From this collective synthesis of information using the 'I see, I feel and I experience,' the student co-researchers then contemplated their learning with a Haiku (see poem below) to summarise their interpretation of the interview transcripts. The student co-researchers had previously used a Haiku in their theoretical learning and suggested this would be a way to summarise their overall learning after synthesis.

Haiku - our Story

Challenging myself
Through the impacts of others
I must remain strong

Clinical supervisor

The same process was undertaken with the clinical supervisor co-researchers as had occurred with the student co-researchers. Of the five clinical supervisors who participated in the 'synthesis with researcher workshop', 4 chose painting and one chose words to represent their individual interpretation of the interview findings. The image (see Image 9-4) below depicts these representations.

Image 9-4 Synthesis: Clinical Supervisor Co-researcher (2019)

All of the above representations were then arranged together, and the clinical supervisor co-researchers contemplated the memories that were made for them, using 'I see, I feel and I experience' (Dewing et al. 2014). The following words portray their collective thoughts:

I see
Colours
Connectivity
Thought-provoking
Diversity
Emotions

I feel
Happy
Teamwork
Smiley

I experience

Nothing was stated under this section. I did leave time with silence for the group to contemplate and add to this section however after I challenged them to contribute, they indicated they did not have anything to add. I felt this was strange and had not experienced this before.

Following this synthesis, clinical supervisors also agreed to complete a Haiku (see poem below) together to summarise their shared learnings and interpretations. The use of the Haiku was shared in the workshop as it was something the co-researchers had used very effectively, and all clinical supervisor l agreed this would be a positive but also a challenging way to demonstrate their overall learning.

Haiku - our Story

We love what we do
Students are worth the challenge
Facilitation

The issue of holding space was raised by the clinical supervisor co-researchers, which had not been raised in the previous student workshop. There was a critical dialogue between participants about holding space. The group felt that for them holding space was represented in the following statements:

- Open the space for them (student) to grow
- Giving them (students) some of you
- Bringing your entire presence
- A space for guiding them (student)
- A passive space
- A space to role model but encourage them (students) not to copy us but be their own person
- Being with them (students)
- Walking with them (students)
- They should end up where they need to be
- It could be a place of limbo, an unknown space.

Researcher reflection following beginning to listen and wait with patience

Following both meetings, I again undertook a reflective process using Dadirri as a form of contemplation and reflection (inner deep listening and quiet still awareness) and creativity (Ungunmerr 1988). For the student 'synthesis with co-researcher workshop', I felt and heard creativity, insight, a level of evaluation and reflection. It was rewarding to see and experience. I felt that the creativity that the student co-researchers engaged with, was the conduit for them to reveal the gem of the shared story they created through the use of a Haiku. Shown in the image (see Image 9-5) below, I have displayed what I felt helped student co-researchers to dig deep and to unpack the layers of their learning to reveal the gem in the workshop. Co-researchers were influenced by their individual experiences and reading through their insights and learning, it helped them to share their unique lens during the 'synthesis with co-researcher workshop'.

Image 9-5 Researcher Reflection on Student Co-researcher Synthesis (2019)

Reflecting on my thoughts and feelings after the clinical supervisor 'synthesis with co-researcher workshop', I believe I heard and felt a struggle to unearth the meaning within their experience to develop relationships with students during their clinical placement experience. There was confusion expressed at times, however, I eventually identified the unearthing of a gem when they began exploring the concept of creating

space. In the image (see Image 9-6) below, this unearthed gem is shown sitting under layers and these layers need to be explored and considered before the gem is revealed. Also in this picture, I feel that the different layers also represent me listening and trusting that the clinical supervisor co-researchers themselves have what is required to unearth the gems or as described by Bhaskar (in Bhaskar and Hartwigg 2010) the genius within (see Chapter 6). My belief following this synthesis is that I need to learn patience and refrain from peeling back the layers prematurely, so I may capture the full extent of the gem when it can be revealed in its entirety.

Image 9-6 Researcher Reflection on Clinical Supervisor Co-researcher Synthesis (2019)

Where I sat as a person-centred researcher challenged me at this point, I was not aware that I was taking the third space as a researcher (Kerr and Sturm 2019). I was concerned my contribution would influence the way the co-researchers' synthesised information and that I could potentially influence their overall learnings. Through a process of critical self-reflection (Mezirow 1990), I realised that my role was to facilitate the workshops to be open and that what emerges is right for this group of co-researchers. I need to learn to listen and wait with patience. A key learning for me has been the vulnerability and challenge you face as you grow as a person-centred researcher. The consideration of my learnings as a person-centred researcher has been further explored in the Reflexivity (see Chapter 11). I did feel very vulnerable and uncertain during the

research information collection journey. I believed that I needed to trust the process and wait with patience, to sit with my discomfort and my vulnerability and trust that the co-researchers have within them to provide what is needed for the research. Listening and waiting with patience resulted ultimately in the unearthing of learnings that added to what is known about the development of healthful relationships in the non-classroom setting and their influence on transformational learning.

Learning Patience and Not to Worry

This section of the chapter moves to the second round in part one of the research process, titled learning patience and not to worry. Being mindful that participants are mostly different than the previous round, the 'synthesis with co-researcher workshops' were conducted in the same way as for the previous round. Seven student and 10 clinical supervisors agreed to participate as co-researchers. The workshops were held on 7 December 2019 for student co-researchers and for clinical supervisor co-researchers on 18 December 2019. Synthesis within part one was designed to have revealed the voice of each of the two groups rather than that of the researcher. Synthesis of the information collected in round two again occurred in two separate groups (student co-researcher and clinical supervisor co-researcher) using only round two collated information. The workshops were conducted as group informal conversation interviews (Cohen et al. 2018) and as participant preferred Zoom meetings. To commence the workshop, I shared my reflections on the interview process with the participants of each group, allowed space for questions but again no questions were forthcoming from either group. The learning from Dadirri and listening with patience was discussed and acknowledged as being a progression to learn from the patience exercised in round one and that we need not worry as to what will be revealed but rather to trust that through deep listening and quiet still awareness the gems required will be unearthed (Ungunmerr 1988).

Following this sharing, participants considered the information within the de-identified transcripts again via access to a secure UOW Dropbox. The participants considered, contemplated and reflected on the salient points of the information from their group. Each participant individually represented their interpretation of the findings from the

transcripts using creative methods. Then they shared their learnings and participated in further critical reflection and critical dialogue (Mezirow 1990). Both groups concluded with the summarising of their shared learnings into a Haiku.

Student

The student co-researchers in round two, chose to use pictures, cards and drawing (Dewing et al. 2014) to represent their individual interpretation of the interview findings, see (Image 9-7) below:

Image 9-7 Synthesis: Student Co-researcher (2019)

Seven students participated in the round two ‘synthesis with co-researcher workshop’. All of the pictures created by the student co-researchers were then arranged together and the participants considered the memories that were made for them, using the organising words of ‘I see, I feel and I experience’ (Dewing et al. 2014) as detailed below:

I see

A 50/50 experience – good and not so good parts and experiences

Two parts make a whole

The importance of guidance and teamwork. With teamwork everything is positive

A team effort

Teamwork

Emotions and experiences

I feel

Everyone has a different experience

50/50 half positive and half negative

A divide of emotions as well as similarities

Students need to work hard to create opportunities to learn

Students need to constantly remind ourselves not to fall into a negative space

If a clinical supervisor is grounded and professional leads to a good experience for students

A positive experience is when the clinical supervisor wants to teach

Students need to put in the effort to want to learn

A fantastic clinical supervisor opens up opportunities to learn – students need to want to learn and clinical supervisors need to want to teach

I experience

Team meetings in the afternoon are about sharing experiences

One on one feedback

Positive reinforcement

Professionalism

Authenticity

Critiquing comes with respect

Want to learn

Haiku - our Story

At the end of the synthesis process, the student co-researcher group was challenged to bring together their synthesis in the form of a Haiku; they managed to do this well and worked very collaboratively to achieve the Haiku below:

Haiku - our Story

Anticipation
Positive and stained for some
Growth between all of us.

Clinical supervisor

The same process was undertaken with the clinical supervisors as had occurred with the students. Ten clinical supervisors participated, and they chose drawing, pictures and words to represent their individual interpretation of the findings. Image 9-8 below depict these representations.

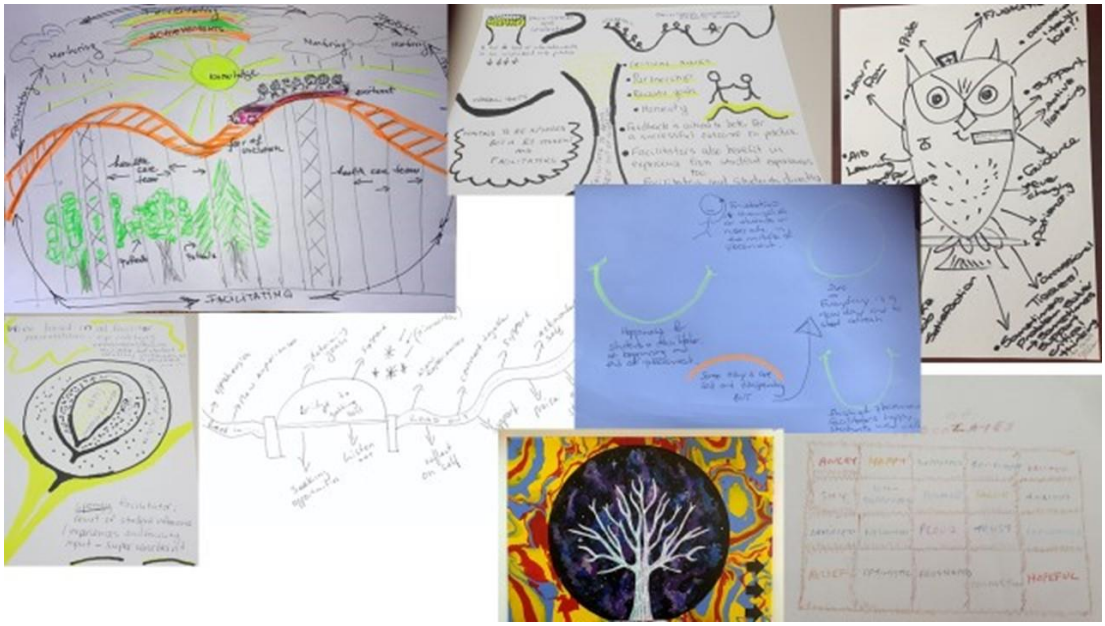


Image 9-8 Synthesis: Clinical Supervisor Co-researcher (2019)

All of the above representations were then arranged together with the clinical supervisor co-researcher considering the memories that were made for them, using 'I see, I feel and I experience' (Dewing et al. 2014). The following words portray their collective thoughts:

I see

A journey

Emotions

Emotions

Emotions

Positive emotions

The commonality of a journey

We work in isolation and connect with others

I feel

Excitement with the rollercoaster

The connection that we are all experienced in different ways but similarities

Similar experiences

Reassured that we have similar experiences in working with students

It is good that others have challenges as well

A sense of relief we have a similar approach

How important the relationship is to get the best out of experiences

The broad role we do – relationships are varied and can change day to day, hour to hour

Need to be open and honest with students – we are travelling the same journey with them

Vulnerability

I experience

Rollercoaster of emotions

Personal satisfaction

A journey that is nice

Acceptance of the challenge in creating relationships with students

Following synthesis of information, they then completed together a Haiku to summarise their interpretation as shown below:

Haiku - our Story

Again, at the end of synthesis, the clinical supervisor group was also challenged to bring together their synthesis in the form of a Haiku. This group found the task a little more challenging than students However, one participant took the lead, which led to a conversation where they managed to achieve the poem below. One of the clinical supervisor co-researchers attempted to lead the group and although the others were challenged to agree on the words for the poem, they appeared to resist any suggestions or directions from the one person who tried to step forward:

Haiku – Our story

Facilitation
Challenging and Rewarding
Communication

Initiated by the clinical supervisor group, we had a conversation on the importance of the supervisory relationship with the following comments forthcoming:

- Challenges are individual
- Need to go in quick – establish the relationship and build trust
- Need to take time to draw out from students they need to be in control of the experience they want to get
- We do not prescribe their learning for them, needs to come from within themselves
- Every student is similar however they all come with different skills and knowledge of life. Some find it easier to slot in – our job is to help those who find it challenging to slot in
- Consider areas I need to build in – experiences from our reflection – we learn about ourselves.
- Growth for us as well
- Marvel on the profession of nursing
- Not just about clinical nursing – nursing is worldwide

The clinical supervisors again considered the concept of holding space for students, and they thought this was represented in the following statements:

- A trusting place
- Openness
- Encouragement
- Step out of comfort zone
- Try new experiences
- Understanding of the journey – helping them understand this
- Walking with someone – allow them to be who they are. We don't do that well in nursing
- We don't allow them to be themselves we try to get them to fit in
- If we help students to be themselves it raises their awareness of difference, helps them to be able to identify good and bad cultures and where they stand with that. What can they learn from culture – right or wrong?

Researcher reflections – Learning patience and not to worry

Following both Zoom meetings in this part of the research process, I again undertook a reflective process using Dadirri as a form of contemplation and creativity (Dewing et al. 2014; Ungunmerr 1988). For the student co-researcher workshop, I felt and heard creativity, insights and depth. I felt a sense of excitement with the depth of the synthesis and depth of the insight that students shared about their role in creating relationships with their clinical supervisors. I felt that there was frustration with what could have been, and I experienced gratitude for the openness of this group and their vulnerability in sharing their experiences with me. I was pleased to hear that there was a great deal of insight into the creation of relationships the tree and sun in the image below (see Image 9-9) represent for me growth and flourishing.

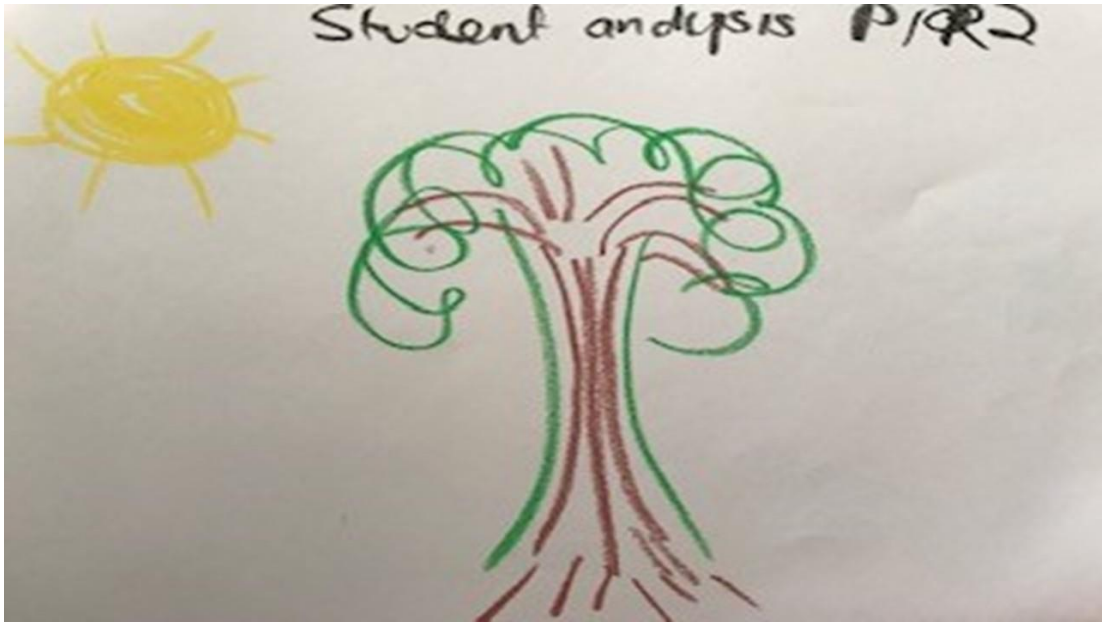


Image 9-9 Researcher Reflection on Student Co-researcher Synthesis, 2019

Reflecting on my thoughts and feelings after the clinical supervisor co-researcher workshop, I felt an energy and depth that was not present in round one. I saw some participants' struggle with the process however they all stood up to the challenge and showed a greater depth in their contemplation (Ungunmerr 1988) and critical reflection (Mezirow 1990) during synthesis. I heard that a relationship is a journey, and each journey has similarities and differences and that there are rewards and challenges. The image below (see Image 9-10) demonstrates the journey of clinical supervision and the highs and lows that come with the role. I felt growth in sharing stories and experiences, and I experienced the group offer and accepted high challenge and high support to each other and me as a third space researcher (Kerr and Sturm 2019).

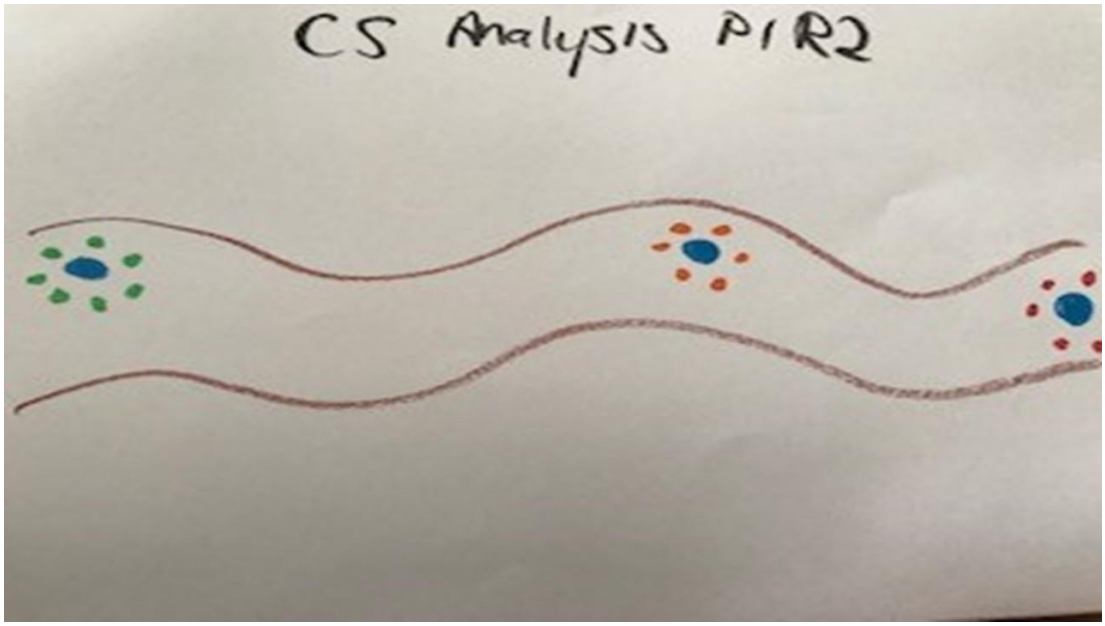


Image 9-10 Synthesis: Researcher Reflection on Clinical Supervisor Co-researcher (2019)

With part one of the PhD research ending with this synthesis workshop, I was hopeful that there was sufficient information however again I learnt much about myself as a person-centred researcher (see Image 9-10). As stated earlier, I had a realisation that although I considered myself as an insider-outsider researcher, however through this research I came to realise that as a person-centred researcher, intuitively the third space is my right space (Kerr and Sturm 2019). I never felt not involved during the research rather comfortable with listening and contemplating the experiences and learnings that were being shared and I felt I was not worrying as much, rather I was learning to sit with my own discomfort and trust that patience was the right way forward. Further consideration of my learnings as a person-centred researcher has been further explored in the Reflexivity Chapter (see Chapter 11).

Synthesis with Co-researcher - Part Two: The Power to be Reborn

This section of the chapter explores part two of this PhD research, where the participants become co-researchers for the synthesis of the information collected within this PhD research. This part of the synthesis process extended the initial synthesis above as it combined the findings from all of part one. Participants again can choose if they wish to be co-researchers for part of the research process. Moving to

part two for me was both exciting and daunting as the information collection was now completed and the finality of this was now a reality. The initial synthesis in part one was exploring healthful relationships and what they mean from student and a clinical supervisor perspective. This second synthesis phase provided the co-researchers an opportunity to explore the relationship between healthful relationships and person-centred transformational learning. Finally, the co-researchers critiqued the theoretical framework that I had developed 'Person-centred Transformational Learning in Practice' (see Chapter 6). The image (see Image 9-11) below is the original draft as this was the version of the theoretical framework reviewed at this point in the research process. The final model is presented in Chapter 10 and includes the changes that were recommended from the synthesis with co-researchers (see Chapter 10).

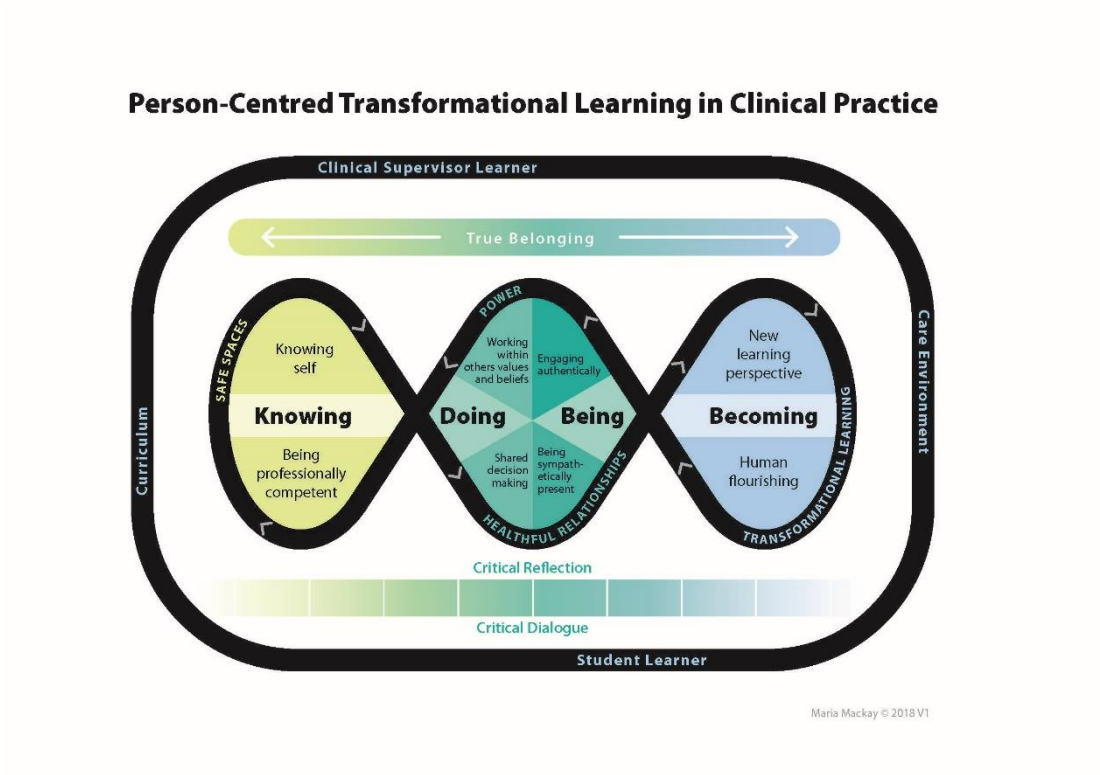


Image 9-11 Person-centred Transformational Learning in Clinical Practice (2018)

My original idea as designed by potential participants during the ethics phase (outlined in the Methods Chapter (see Chapter 7) was that the students and clinical supervisors come together, share their learnings and perspectives and ultimately create one shared story. This however was not supported by the UOW Ethics Committee and the reality for this research is that the groups remained separate. Resulting from this decision a final synthesis and meta-synthesis was incorporated into the research and is presented in Chapter 10, where all information including previous findings are synthesised by myself as the principal researcher. In line with the hopeful message that Dadirri provides that we all have the ability to listen and learn from one another with patience, I took the view that each group synthesising their learnings separately as an opportunity to discover rich information. The Dadirri poem finishes with the words "I believe the spirit of Dadirri that we have to offer will blossom and grow, not just within ourselves, but in our whole nation." For me, this is the meaning and wisdom that will come from each groups' shared understandings (Ungunmerr 1988). The voice of each of the separate groups (students and clinical supervisors) was illuminated within this section of the chapter.

For me, synthesis was challenging as it confronted my ways of being as a person-centred researcher and challenged me to stay true to my methodological principles. During synthesis, I considered where I sat as a person-centred researcher that is, neither as an insider nor outsider, but rather I had assumed the 'third' space as described by Dwyer and Buckle (2009). The third space is where I have a shared purpose with the co-researchers and a somewhat shared understanding of being a student and a clinical supervisor, however I did not assume that I completely understood the participant's perspective (Kerr and Sturm 2019). I feel the third space for me is where I am able to authentically be myself and engage with the co-researchers in a way that feels right for me and where I begin to learn to trust my intuition as a researcher enabling the creation of healthful relationships between all in the group. In the reality of the synthesis, I was faced with a disorientating dilemma (Mezirow 2000) I had thought that I would be an insider-outsider researcher in this space, however, I realised this was not the case and in fact, through my discomfort, I discovered the concept of the third space. I feel I am situated comfortably in the third space as I am not completely different or completely the same as either group of co-researchers. Through a process of critical dialogue and critical reflection (Mezirow 1990), I related my new learning perspective (Mezirow 2000) of the third space to the definition I have given on personhood in Chapter 4 (see Chapter 4), being that each participant and co-researcher is able to determine their own personhood and their own reality as a researcher. I, therefore, felt I had found my place in the third space enabling my personhood. I believe I was authentically able to listen, contemplate and facilitate the process of co-researcher and therefore enhancing synthesis in this third space. Further, I believe allowing myself to intuitively meld with the group enabled the co-researcher voice to be heard and acknowledged which resulted in the co-researcher led creation of knowledge and a shared benefit of learning about ourselves as practitioners (Dwyer and Buckle 2009; Williams and McCormack 2017; Kerr and Sturm 2019). In the third space as a person-centred researcher, I also relate to purposeful turbulence as described previously in the Methodology Chapter (see Chapter 7), where we learn together through the process of turning the inherent turbulence of practice into a purposeful learning experience. As a result of the complexity of person-centred research, I feel that there is a part of the process where t there will always be and should be turbulence and discomfort. The complexity and

uncertainty of trusting that others (participants and co-researchers) have within them what they need to unearth the gems within the research information collection journey created uncertainty, however it is through navigating this turbulence to be purposeful that I have learnt to trust the research process, the participants and co-researchers.

Clinical supervisor synthesis with co-researcher workshop

The clinical supervisor 'synthesis with co-researcher workshop' is being presented before the student workshop as this was the first workshop that was conducted and there are learnings from this that are shared in the student 'synthesis with co-researcher workshop'. All clinical supervisors who were participants from both rounds in part one were eligible to be co-researchers and were approached via email (see Appendix O) to invite them to participate in this part of the research. As described within the Methods Chapter (see Chapter 7) the recruitment of the clinical supervisor co-researchers for part two was completed quickly with a good response. The meeting was scheduled, and all participants attended, which I was both very pleased and relieved about. The clinical supervisor workshop for part two was held first and it was at this point I again began to consider my role in the workshop and how the third space would look for me as a researcher with this group (Kerr and Strum 2019). I believe that I took on the role of facilitator and engaged in active listening, not to be objective in the process but to rather provide space for the voice of the co-researchers to be loud and heard (McCormack et al. 2017). I was mindful that I was seeking rebirth of the information in the synthesis and was concerned that my voice in the workshop would influence the critical dialogue in the group.

The workshop was held on 20 January 2020 at the UOW, Wollongong Campus with eight clinical supervisor co-researchers, myself and one other academic staff member. Six clinical supervisor co-researchers attended the two-hour workshop in person and two participated via Zoom (eight clinical supervisor co-researchers) meeting at the participants' requests.

We introduced ourselves and the clinical supervisor co-researchers explored their role in the workshop. We then agreed on the purpose of the workshop as collaborating

together to explore their key learnings and consider what they have learnt about themselves in a relationship with students and how healthful relationships impact on Person-Centred Transformational Learning in Clinical Practice. We then read the Dadirri poem and discussed the importance of taking time for contemplation using inner deep listening and quiet still awareness as a process for the unearthing of the learning and insight each of us brings to this workshop (Ungunmerr 1988).

Healthful Relationships

We next moved to explore a combined Wordle that included words from both rounds in part one (only from the clinical supervisor part one co-researcher meetings) of the research information collection. This Wordle was made from the words of the participants that they shared in part one of the research processes. I combined the words for each group into one wordle for students and one for clinical supervisors. This was done to synthesise all of the words into one Wordle for the co-researchers to review. Although I made the Wordle, the words are from the students and clinical supervisors themselves. They had time to contemplate the Wordle (see Image 9-12 below) reflect on this and to consider what spoke to them and if they would like to change the image in any way.

Image 9-12 Combined Clinical Supervisor Healthful Relationship Wordle (2019)

The clinical supervisor co-researchers did not want to remove anything, they did, however, add words, these included:

- Validation
- Optimism
- Satisfaction
- Enthusiasm
- Humour
- Wonder
- Empowerment
- Assertiveness
- Purposefulness

As part of the clinical supervisor co-researcher synthesis of part two workshop the Wordle was updated as below (see Image 9-13):

Image 9-13 Revised and Final Clinical Supervisor Healthful Relationship Wordle (2020)

Exploring the Person-centred Transformational Learning in Clinical Practice

Following the exploration of the Wordle, the clinical supervisor co-researchers considered the transcribed summaries from the previous workshops where synthesis had occurred (see Chapter 8). They developed their own individual creative interpretations of the salient points that were important to them regarding learning in clinical practice. The learnings from the co-researchers were also unpacked under the areas of Knowing, Doing, Being and Becoming to explore what was meaningful to them and represented creatively. The clinical supervisor co-researchers were able to consider these headings well and were happy to do this without going over the model for Person-Centred Transformational Learning in Clinical Practice. I suggested this as a way of considering Knowing Doing, Being and Becoming as this is what was outlined within the ethics application for the workshop in part two. All co-researchers agreed that doing this organically would work well for them and they could then connect this learning with the model following this activity. This approach was shared with the student workshop as their workshop has not yet occurred.

The following **Error! Reference source not found.**) is a collage of the creativity that the clinical supervisor co-researchers developed via individual creative reflections.

Image 9-14 Combined Clinical Supervisor Creative Collage Part Two (2019)

The clinical supervisor co-researchers then shared the following synthesis of information. They shared their learning from part one under the headings of Knowing, Doing, Being and Becoming below in the same way students previously had done:

Knowing

- Knowing expectations of the role
- Being clear on Subject information
- Scope of practice
- Understanding differences
- How to handle difficult conversations without upsetting students
- Empathy versus sympathy
- Tact – how to talk to students with consideration of words and tone
- A challenge to confidence, this is different from working with patients
- Understanding shared education in the clinical supervisor workshops, and this helps when we get out there
- We expect to be challenged
- It is empowering to explore our role

Doing

- You are there in an assessment capacity and someone they can rely on
- Treating every student as an individual
- Openness
- Honesty
- Communication and togetherness
- Mindful of cultural difference
- Being flexible as every group is different
- Understanding and empathetic
- Conduit of the relationship with the ward staff and students
- Help students to use negative experience positively to become the nurse they want to be
- Reflection

- Being accountable for what we do – role modelling
- Open communication – making students feel comfortable to come forward talking about their issues
- Approachable
- Giving feedback – saying the right words to help maintain the relationship - choosing the right words
- Taking everything back to the RN Standards for Practice (2016), this takes it from being personal and tells the public minimum to expect

Being

- Assuring students you are there to reply on
- Being respectful
- Being trusting
- Being supportive
- In wonder
- Great communicator
- Being understanding
- Being optimistic
- Being passionate about nursing ‘
- Having a sense of humour
- Consider the situation
- Make initial connection
- Consider body language for you and the student
- Be vulnerable - let them know you are human
- Trusting your gut feeling, experience and intuition – the same as in nursing
- Encouraging individual growth and development
- Creating a comfortable environment
- Creating boundaries

Becoming

- Sense of achievement
- Thankfulness – being able to part of being a facilitator
- Reflection on my practice as a nurse and facilitator of learning
- Being grateful to see students complete and enter the profession
- Purposefulness – seeing the light bulb
- Students understanding you are a human – you have made mistakes
- Being open to students teaching you
- Students enthusiasm gives you excitement
- Ageism is gone – they don't see you as older – don't see you as younger – we are both just nurses
- Reflection – gives us growth development and goal setting
- Meaning is important
- Remembering names shows I care
- The research project has helped me to see I am not just me I am new on the outside and have something to offer

Critical dialogue (Mezirow 1990) with clinical supervisor co-researchers about healthful relationships explored how creating healthful relationships with students helps them move from the culture where they used the word of 'eating our young' to be more aware of the needs of students. They also talked about how, if the words in the Wordle (see Image 9-13) above were put in place in practice, there would be a sense of growth for students and consequently, when they graduate, they would stay in practice. In summary, clinical supervisors believed that they needed to acknowledge that students need to engage in a relationship with them, they cannot do it on their own. There was also an acknowledgement that it was part of their role to proactively create healthful relationships throughout the whole clinical placement period with all persons involved.

The critical dialogue (Mezirow 1990) then organically moved to an exploration of active learning, where they viewed active learning to include:

- Students can disappear and it is the clinical supervisor's role to work with students to encourage them to be active in their learning
- Our role is also to challenge students out of their comfort zone as we believe this helps them to engage in active learning
- We limit our ability to facilitate active learning when we have a preconceived idea of what a 1st, 2nd and 3rd-year students should look like.
- Registered nurses do not seem to encourage active learning, rather they seem to believe that students need to be more like them and be busy doing.

Following the discussion on Knowing, Doing, Being and Becoming above, the clinical supervisor co-researchers. then moved on to reviewing the theoretical framework for 'Person-centred Transformational Learning in Clinical Practice' (see Image 9-15); this was shared on A3 pages for those in attendance and for those participating virtually it was on the Zoom screen.

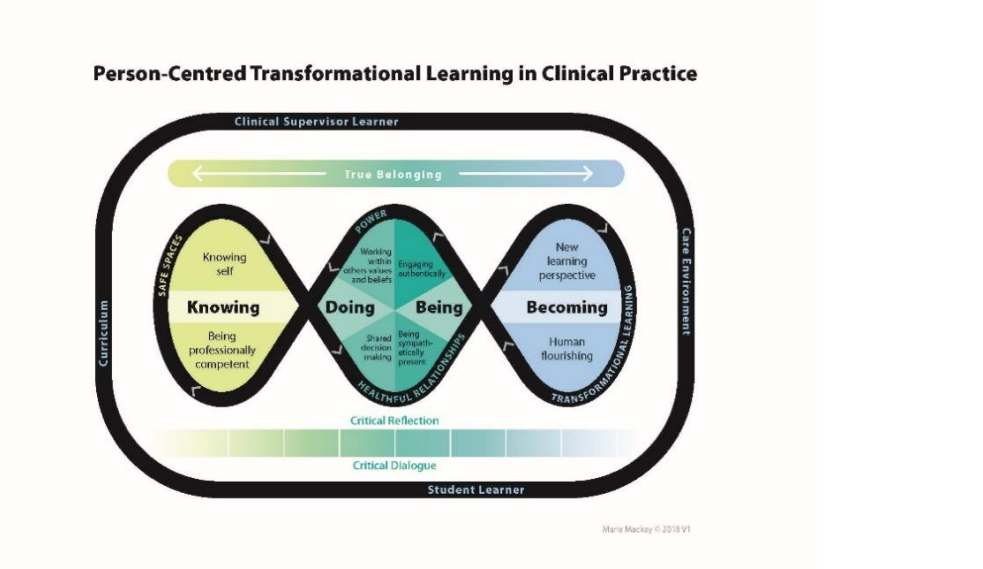


Image 9-15 Person-centred Transformational Learning in Clinical Practice (2017)

We continued by moving to the concept of Dadirri and contemplation, taking time for inner deep listening and quiet still awareness (Ungunmerr 1988). After the participants reviewed the model and contemplated what this meant to them as individuals, I

explained the development of the model and created a space for critical dialogue (Mezirow 1990). There was critical dialogue around how their participation in this PhD research created for them a new sense of awareness and that they were now seeing their role in a different light and had come to see that the model made sense to them (Mezirow's 2009). In the final part of the critical dialogue (Mezirow 1990), the clinical supervisors were again asked if there was anything in the model they did not agree with or would like to add. The participants agreed with the theoretical framework except were opposed to the term 'being sympathetically present'. We then read the definition of 'being sympathetically present' and they agreed that the definition was suitable, however, it was acknowledged that the word sympathy did not sit comfortably for them and they would prefer 'being empathically present.'

We concluded the workshop with me thanking the co-researchers for their contribution. I was genuinely incredibly appreciative and proud of each of them and that I had seen so much growth in their understanding of their role during this PhD research. There were several comments made that have been noted below. Something that occurred to me in our discussions was that most of the clinical supervisor co-researchers were known to me and they indicated that initially, they participated in this PhD research to help me, however as time progressed they now were participating for what they were receiving after taking part in the research, The clinical supervisor researchers shared that by exploring their role and the emotional connections they made from using emoji to reflect on their relationship with students, they felt they grew professionally and personally.

Each co-researcher then provided the following comments individually and I have captured these below:

- Opportunity for introspection and improvement for myself. Challenged me to push boundaries and reflect if what I am doing is right.
- Opportunity to hear others' views. Challenge myself to think about how am I applying this to facilitating learning.
- Opportunity to have a voice. Challenge my understanding of emoji
- Opportunity to love what I do more and now I don't feel alone – I belong
- Opportunity to do a deeper synthesis into my role as a clinical supervisor. Challenge for me was in thinking deeper and understanding about theory and practice
- Opportunity to realise and reassure myself I am on the right track and to reflect on my role. Challenge for me was that I wondered if I had anything to contribute.
- Opportunity to open up about my role as a clinical supervisor. I feel more in control of who I am, Challenge was in considering all students individually and how that affects my practice.
- An opportunity was to be part of the PhD research. Challenge was in collecting the emoji and reflecting.

Student synthesis with co-researcher workshop

All student participants from both rounds in part one were eligible to be co-researchers in part two and were approached via email (see Appendix R). As previously described, the student co-researchers recruitment for part two was challenging for this group as there were many competing demands, including family and work commitments and the impact of the January 2020 bushfires in Australia. The meeting was scheduled and rescheduled on two occasions, which resulted in me feeling an additional level of gratitude for those who participated as well as anxiety where I felt a sense that I needed this PhD research to be finalised. I put a lot of energy into not allowing the synthesis to 'just' be a process, rather be the best it could be and for the student co-researchers to have every opportunity to participate to their full potential.

A workshop via Zoom was held with four student co-researchers on 5 February 2020 over two hours. We introduced ourselves and I explained my role as a facilitator of the workshop. Co-researchers explored their role in the workshop by collaborating to explore their key learnings and consider how their learnings of healthful relationships impact Person-Centred Transformational Learning in Clinical Practice. We then read the Dadirri poem and discussed the importance of taking time for contemplation using inner deep listening and quiet still awareness as a process for the unearthing of the learning and insight each of us brings to this workshop (Ungunmerr 1988).

Healthful Relationships

The first part of the workshop was where the student co-researchers reviewed the Wordle that was created from a combination of the words describing healthful relationships, outcomes from part one, round one and round two (see Image 9-16) below. This Wordle represented the collective thinking of the student participants from both rounds with regard to what is important for them as students to create healthful supervisory relationships with their clinical supervisor in clinical practice.

Image 9-16 Combined Student Healthful Relationship Wordle (2019)

After taking some time for contemplation (Ungunmerr 1988), we had a critical dialogue (Mezirow 1990) about healthful relationships and the students shared the following:

They did not want to remove any words and considered that the following words should be bolder in the above image (see Image 9-16):

- Respect and balance (to be the biggest)
- Listening
- Support
- Honesty

They then requested the additional word ‘partnership’ be included and that this should also be one of the more pronounced words in the Wordle. As a group, they agreed that a sense of partnership was one of the foundations of knowing you were in a healthful relationship. The image below (Image 9-17) is the revised Wordle created within this workshop following the process of critical reflection and critical dialogue (Mezirow 1990).

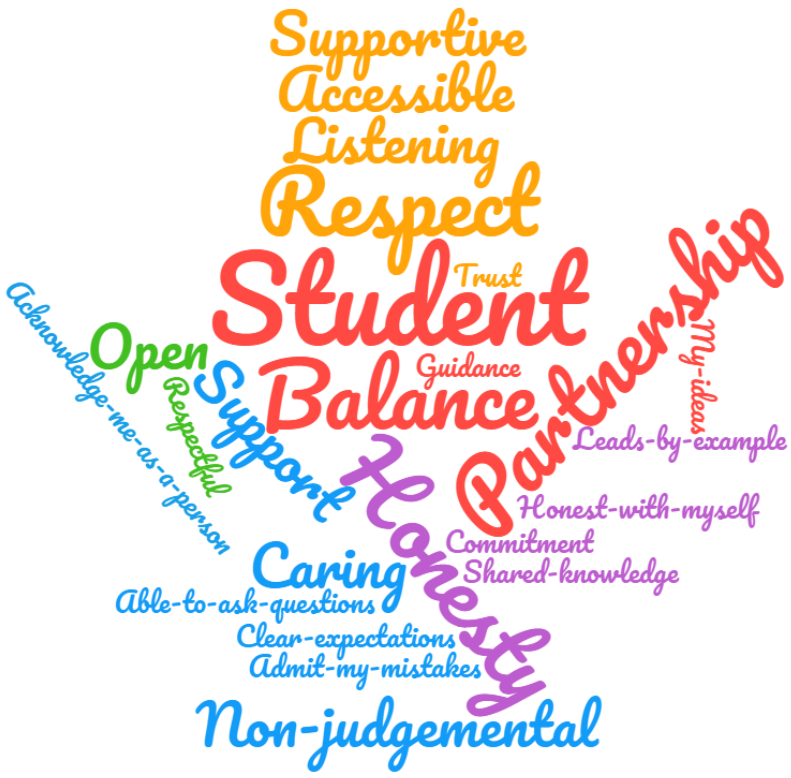


Image 9-17 Revised and Final Student Healthful Relationship Wordle (2020)

Exploring the Person-centred Learning in Clinical Practice

Following the exploration of the Wordle, the student co-researchers considered the transcribed summaries from the two student l workshops where the synthesis of information occurred (from part one following round one and round two) and individually developed their own creative representation of the salient points that were important to them regarding learning in clinical practice. The learnings from the co-researchers were unpacked under the areas of Knowing, Doing, Being and Becoming to explore what was meaningful to them from the creative representations. The concepts of Knowing, Doing, Being and Becoming are fully explored in the Philosophical Chapter (see Chapter 6) and form the basis for the theoretical framework of Transformational Learning in Clinical Practice (see Image 9-19). Exploring Knowing, Doing, Being and Becoming in the context of learning that occurs throughout an academic session shows the influences healthful relationships have on students' transformational learning in clinical practice. The student co-researchers embraced this and took up the challenge to consider how creating healthful relationships with their clinical supervisor influenced person-centred transformational learning. Co-researchers expressed this would help them to authentically consider, through their own perspective of learning, rather than to be influenced by information from the model. This approach had occurred within the clinical supervisors l workshop and was shared with the students.

The following image Image 9-18 is a collage of the creativity that the student co-researchers created by bringing together their individual creative reflections.

Image 9-18 Student Creative Collage - Part Two

The student co-researchers then shared the following wisdom following the synthesis of part two under the headings of Knowing, Doing, Being and Becoming as depicted below:

Knowing

- Knowing self
- Knowing our values
- A realisation that we need to look inwards to look out
- Knowing what you can achieve
- A good understanding of your expectations
- Understanding is ok to be confused by your own emotions
- Wanting to learn and wanting to teach
- Knowing what you want to learn

Doing

- Engaging in active learning
    - Feedback both ways
    - Committed to learning
    - Putting into practice what you have learnt
    - Looking for opportunities to learn

    - Actively seeking opportunities
- Teamwork and working well within a team
- Putting effort into a relationship
- Going in with a positive attitude
- Asking questions
- Seeking opportunities to learn
- Need to have patience with yourself and realise that your supervisor is learning as well

Being

- Being present
- Authentic presence
- Need to practice being to learn it
- Need the confidence to do it
- Lead by example – treat people the way you want to be treated
- Mutual respect
- Look for the registered nurse I want to be and the one I don't – be the one I want to be
- Patients see if you care and appreciate it
- The difference between the Art and Science of nursing- Doing is the science and Being is the art.
- It is an art to get it right and admit when you don't know
- Respecting difference
- Valuing individual beliefs
- Understanding I respect the right for you to have your opinion but I don't have to respect your opinion
- You don't have to respect others beliefs but you do have to respect your role as a nurse
- Create a good quality experience for the people we care for and work with even if your values are different
- Respect difference and walk away or make something positive from it

Becoming

- Embracing that experiencing challenges come with benefits – make it bring you up not let you down
- Individualised – if you're not familiar with personal values or self-awareness about emotions – one thing would be positive reinforcement
- Becoming authentic – helps you to know who you are- or what you believe
- Fight – at times it feels like a battle and it's awful. In these times if you can feel the emotion and catch it and acknowledge it, you can be more authentic
- Inner fight – you think you have it all, definitely felt my values and moral were set in stone – I had to reassess these when I was challenged – I became more aware
- A moment when I was really in judgment regarding wound care – I realised I hadn't asked how they practice and realised I needed to find out more from the Cambodian perspective. I actually realised eventually that although the process was different it was actually quite good. I realised that I needed to be more open to how things can be different from what I know and that I can learn from that.

Following synthesising of information for healthful relationships, the student co-researchers then moved on to the theoretical framework for 'Person-centred Transformational Learning in Clinical Practice' (see Image 9-19), via a Zoom shared meeting.

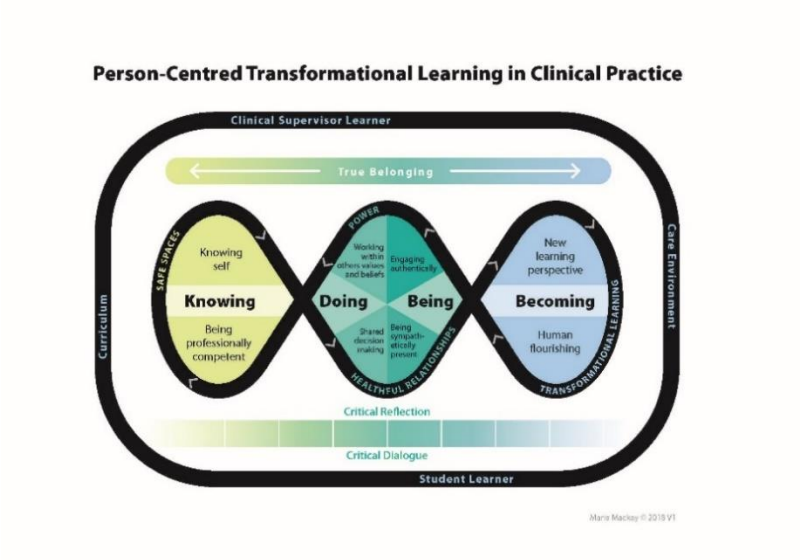


Image 9-19 Person-centred Transformational Learning in Clinical Practice (2017)

During this meeting, we again used the concept of Dadirri and contemplation, taking time for inner deep listening and quiet still awareness (Ungunmerr 1988). After the co-researchers considered the model and contemplated the meaning of this for themselves individually, I explained the development of the model and answered any questions they had. I asked if they agreed, disagreed, or had questions or concerns on any part of this model. The majority of the dialogue was on the concept of true belonging and what this means. In the final part of the critical dialogue (Mezirow 1990), the student co-researchers were again asked if there was anything in the model they did not agree with or would like to add, unanimously they agreed with the model and did not want to change any part. A comment from one of the student co-researchers was that it encompassed all the significant aspects of learning for them. I shared with them that the clinical supervisors had requested to change the one part in the being section of the model from being sympathetically present to providing holistic care (McCormack and McCance 2017). When the definitions of both these terms were read out, they unanimously disagreed and stated they were happy to leave being sympathetically present as initially presented.

Comments on preparation for learning in SNUG104 and SNUG108 (clinical placement subjects in year 1 of the BN)

The final part of the Zoom workshop arose from student co-researchers themselves

relating their experience of learning in clinical practice to the academic learning in the theory subjects. As part of their first-year subjects, students completed 2 academic sessions or semesters and in each academic session they completed a workplace experience subject which consisted of 10 weeks of online learning and 10-day clinical placement; these subjects were SNUG104 – Workplace Experience 1 and SNUG108 Workplace Experience 2. They also completed three other academic subjects with all subjects relating to their clinical placement. We undertook a critical dialogue (Mezirow 1990) on the contribution that the workplace experience subjects had on their readiness for practice with participants sharing the following information:

- 100% exploring and understanding my values taught me that looking in helped me to give out
- One student undertook subjects in the previous curriculum as the current curriculum was in its initial year and commented on the newly designed curriculum for SNUG108 only. This student had received credit for SNUG104. She stated that SNUG108 far surpassed anything I learnt in the old curriculum. I learnt so much of who I am and consider my practice in a different way. I am so much better prepared than in the previous curriculum.
- It made me pick apart myself and my interactions with others.
- I was prepared to deal with other people and with my supervisor.
- If I had not done this work, it would have been so much more difficult.
- I needed this preparation to deal with the reality of practice.
- Reflection has been fundamental both SNUG104 and SNUG108 prepared me for this.
- I think for people who have just left school, a lot did not see the value in the learning of the workplace experience subjects, people who enter the degree later in life value the learning and emotional challenges in these subjects.
- SNUG104 and SNUG108 prepared me for placement and they also impacted on my life.
- Need some initial modules as to what this is important as there is a lot to consider in online learning and the modules.
- Self-learning modules are complex, better in the classroom. Doing this in person you are able to bounce off one another.

Conclusion of 'synthesis with student co-researcher workshop': part two

We concluded the workshop with me expressing gratitude to the co-researchers for their participation, insight, and courage. I then asked for feedback from the students about their experiences after participating in this PhD research and the following information was shared:

- Useful to reflect on how our clinical placement has been beneficial to our overall learning.
- It helped me to consider how I create a relationship with my clinical supervisor, I had not really thought about this before.
- I was able to understand from being part of this PhD research what a good clinical supervisor is and what I feel is not good supervision.
- I found the process interesting in going through the emoji and being interviewed. I went into my placement being certain of who I am and what I would do and what my values are. Through reflecting using the emoji, I realised I needed to do a lot of work as I did not react and respond to how I thought I would. I would not have learnt that about myself if I did not do this research.
- Participating will benefit me moving forward.
- I feel I was accommodated more than I accommodated for the PhD research. It was really good to look further into the emotional side of being in clinical placement, it was really cool.
- Collecting the emoji and them talking about them again in the interview was like double reflection and learning.
- Having Maria catch up and remind us to collect emoji, interviews and now in this meeting, it helps me to stay engaged with my learning.

Researcher reflections – Part Two

I began the 'synthesis with student co-researcher workshop' with so much gratitude to the four students who participated in this workshop and anxious as I knew they had all sacrificed their time away from work and their families to participate. I instantly felt a sense of we can do this when the student co-researchers introduced themselves. I felt and heard a commitment to contributing to what is known about learning in clinical practice. The image (see Image 9-20) below demonstrates a sense of flow that I felt in

the workshop, with the dotted spots depicting the gems that I heard from the student co-researchers. As with the previous synthesis workshops that I undertook with students, I am in awe of their wisdom which reinforced my belief that year one students have a lot to contribute to the development of learning and teaching resources.

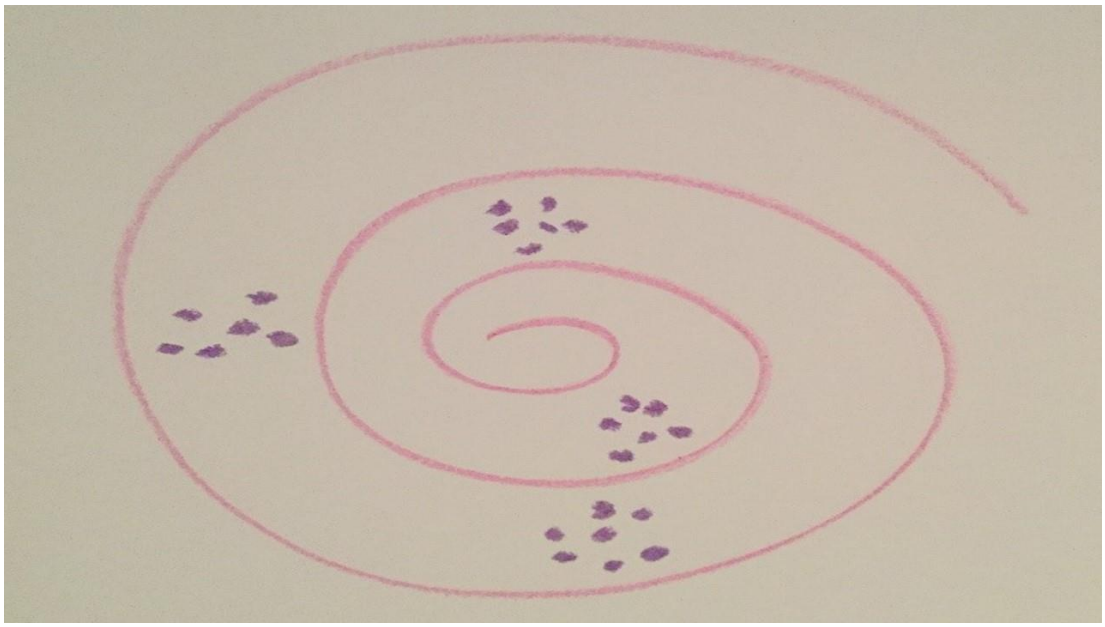


Image 9-20 Researcher Reflection Following the Student Co-researcher Synthesis Workshop

Overall, I felt honoured, grateful and relieved that the 'synthesis with student co-researcher workshop' was completed.

Reflecting on the 'synthesis with clinical supervisor co-researcher workshop', I began the workshop feeling anxious yet concluded them feeling such a sense of awe and wonder along with excitement, that this group of co-researchers had grown so much over the time and we have been considering healthful relationships together. Going into the workshop, I felt anxious about the clinical supervisors' ability to reveal the gems I was hoping would inform my research. For my own benefit, I had to bring myself back to my methodological principles and believe in each of them and the process of research. I also had to let go of gaining information that I was looking for and trust the information that would be unearthed would be the right information. The Image 9-21) below demonstrated that I do believe the use of emoji, creativity, critical reflection and critical dialogue (Mezirow 1990) in conjunction with Dadirri as

contemplation (Ungunmerr 1988) is powerful. I felt anxious because this was the final part of the PhD journey and I felt an overwhelming sense to complete part two and yet wondered if it would be enough to inform the PhD research. Being true to my methodological principles, to demonstrate that I believe people have within them what is needed for them to learn and flourish to their full potential, I needed to trust the process.

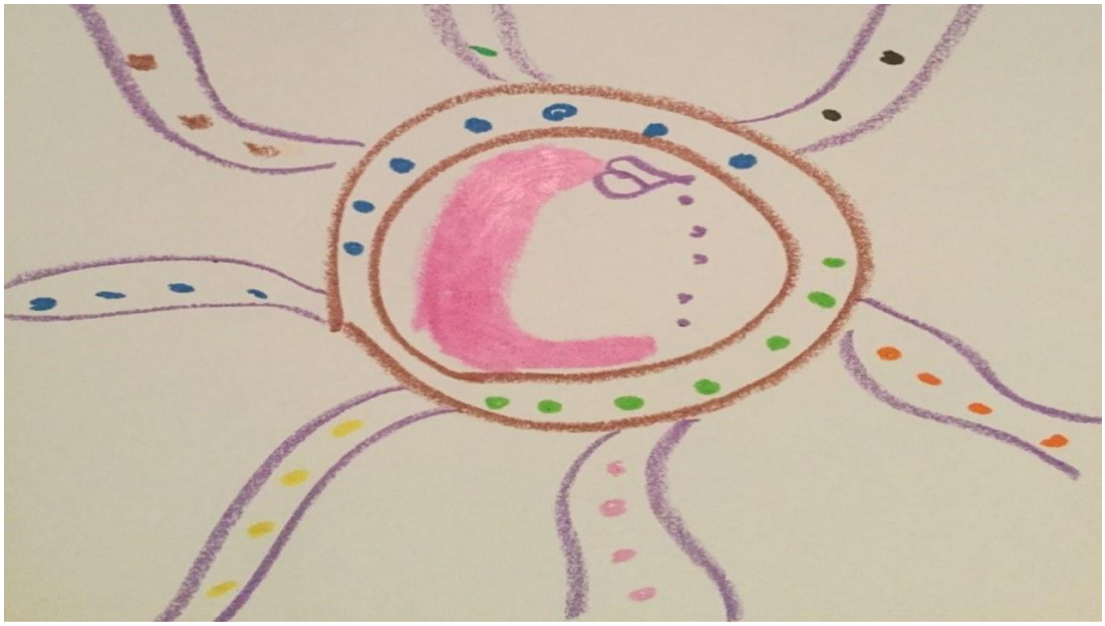


Image 9-21 Researcher Reflection Following the 'Synthesis with Clinical Supervisor Co-researcher Workshop' (2019)

As we were working through synthesis, I felt a sense of gratitude that each person was sharing rich heartfelt information. I was so pleased to take this PhD journey with each of them and experience their ability to speak to the information they collected and to see how dynamically they changed after hearing their insights into their own practice.

Chapter Summary

In conclusion, this process of synthesis with co-researchers was a challenging but rewarding step within the research process. The information and gems revealed have given voice to the perspectives of a healthful relationship and its influence on person-centred transformational learning from the student and clinical supervisor unique perspectives. Each of the 'synthesis with co-researcher workshops' was unique in their

own way and this was a strength of using informal conversation interviews to guide the workshops. I believe this allowed for enough consistency in what was discussed however also provided the space for individual learnings from each group to be illuminated. There were six workshops in total, four in part one and two in part two, with each one providing insight and perspective that helped us to understand the crafting of healthful relationships and their influence on person-centred transformational learning. I felt both challenged and satisfied with the gems that emerged. My challenge moving forward was the hope that I am able to bring all of the voices that have been present in this part of the research process authentically into a shared story where each of the co-researchers will be able to see their contribution.

The overall summary of this chapter is presented in the poem below:

Poem

Co-researchers what does that mean
Will they be interested
Will they have time
Will the gems be there for them to see

My role in co-research'
Who am I and how do I fit
Do I need to belong or can I just observe
How do I fit in when I don't really belong

How do we synthesise
Who knows how to synthesise
Is this too much to ask
Taking one step at a time

Voices, Voices, Voices
The student voice is unique and articulate
The clinical supervisor voice is uncertain but powerful
My voice is yet to come

As this chapter comes to an end, I am reflecting on the learning and transformation of learning perspectives that occurred for all persons involved in this research (Mezirow 2000). As the principal researcher, I now have the task of moving forward to Chapter 10 and combining the voices that have emerged within this chapter through my own process of reflection and synthesis into one shared story. The shared story will reveal the discoveries from this PhD research.

Chapter 10

Discoveries in Synthesis and Meta Synthesis

Image 10-1 Discoveries in Synthesis and Meta-synthesis - © Maria Mackay 2020

Introduction

In this chapter, I aim to critically discuss the synthesis and meta-synthesis of the information collected as part of this PhD research and share the collective story or understanding that has been discovered. The image (see Image 10-1) above represents the process of contemplation that formed part of this process of synthesis. Firstly, I begin with the development of the approach to synthesis where I outline four key steps that were undertaken to synthesise five sets of information from the PhD research to combine phenomena into a transformed whole. The participant and co-researcher information was synthesised to create a shared story that addresses the PhD question of how do healthful relationships between students and their clinical supervisor influence person-centred transformational learning? It is important to remember that these participants were not able to come together for ethical reasons associated with power, as previously stated in the Continuing the Journey to Methods, Chapter 8. Purposefully, to demonstrate that both voices are important, I have explored the voice of the student first before that of the clinical supervisor and I have provided balance

for each groups' combined voice plus given equal volume to each of the group's voices. In communicating the shared story, the research question has been presented as two distinct parts where discoveries emerge. The first set of discoveries defined what a healthful relationship between a student and clinical supervisor is, using the voices of the participants and co-researchers. I then moved on to consider how healthful relationships influence person-centred transformational learning and bring this to the level of meta-synthesis of the voices of the participants and co-researchers against the theoretical model developed in the Taking the Road to Developing a Theoretical Framework, Chapter 6. I remain in awe of the insight and deep connection to their own learning that the participants and co-researchers shared with me and I believe that I have given justice to their combined story.

Development of an Approach to Synthesis

I am undertaking a final synthesis to bring all the parts of this PhD research together. This synthesis of information brought together information collected from student and clinical supervisor participants and co-researchers in parts one and two of the larger research. As previously indicated in The Cobbled Road to Information Collection and Synthesis with Co-Researchers Chapter 9, I originally hoped that the combined synthesis of information would be completed collaboratively with co-researchers from the student and clinical supervisor groups together. Unfortunately, I was not able to combine the groups, therefore, I completed this synthesis as the principal researcher in collaboration with my supervisory team. The co-researchers in their separate groups then validated tentative findings. In undertaking this synthesis, I aimed to ensure the student and the clinical supervisor voices remained prominent, while at the same time, I was also finding my voice in sharing the story or understanding as a person-centred researcher situated in the third space (Kerr and Sturm 2019). As discussed in the Exploring Person-Centred Methodology Chapter 7, the third space is a concept, whereas as a researcher, I do not consider myself an insider or outsider. Instead, I found a unique space where I am positioned as a person-centred researcher, one that respects that the knowledge and attributes I have are both similar and different to the participants and co-researchers (Kerr and Sturm 2019). I have walked this journey with the participants and co-researchers and feel within this synthesis, it is my responsibility

to create the shared story that ensures as the discoveries surfaced, all our voices were present.

In considering the approach that I use for the synthesis of the final information, I examined the terms analysis, synthesis, meta-analysis and meta-synthesis. The term analysis in this context refers to qualitative analysis and this is defined by Polit and Beck (2018, p. 395) as 'the organisation and synthesis of data' (or information) 'to answer the research question'. Cohen et al. (2018, p. 643) refer to qualitative data (information) analysis as moving from data or information to a point of understanding. Meta-analysis is considered broadly a quantitative approach where synthesis is a qualitative approach (Polit and Beck 2017). Synthesis is described as "the process of resembling parts into a comprehensive whole" (Howel et al. 2010, p. 183). The information I have collected is in the form of words and pictures and other creative representations, therefore I have described the process of synthesis as a form of qualitative synthesis Centre for Reviews and Dissemination (CRD) (2009). A qualitative meta-synthesis is defined by CRD (2009, p.229) as a "set of techniques for the interpretive integration of qualitative research findings." When exploring this, I found there was information on synthesis and meta-synthesis from a literature review perspective (Polit & Beck 2017), however, I could not identify a framework for the synthesis of unpublished work or interpretative integration of PhD research findings. Therefore, I propose that my definition of the approach to final synthesis I undertook, was a creative process for the interpretation of information collected across the entirety of this PhD journey, that enables the interpretation of the key messages participants and co-researchers shared, enabling discoveries through gaining insight and new perspectives related to the PhD research question.

Synthesis was undertaken to interpret the information collected to date in this PhD research and consisted of five main sources; all five information sources had the voice of the participants and co-researchers as an integral part of them. These were:

1. The student led conversation publication (student voice)
2. The participatory literature review publication titled 'How do we consider the impact of clinical supervisor education? A participatory literature

review' (clinical supervisor voice)

3. The interview transcripts and the participant in part one, round one and two, (student and clinical supervisor voices)
4. The transcripts from the co-researcher analysis workshops in part one following round one and round two (student and clinical supervisor voices)
5. The transcripts from the co-researcher synthesis part two transcribed workshops (student and clinical supervisor voices).

The lens for synthesising was informed and influenced by my ontological, epistemological and methodological principles. Within the table below (see Table 10-1), my ontological, philosophical and methodological principles are entwined within the Person-Centred Methodology for Exploring Healthful Relationships in Practice, (see Image 10-2). My PhD journey to this point informs the shared story that will be created as it influences how I hear and experience the voice of the participants.

Ontological Principles	Philosophical Principles	Methodological Principles
I believe: • I experience the world of nursing through the lens of a paediatric nurse; • a person's experience of family and culture influences each of us in our personal and professional way of being. • the art of caring is both innate within us as persons, as well as a skill that can be learned and will develop over time. • it is a challenge for the nursing profession to consider how we bridge the gap between university education and clinical practice for students. I value that: • registered nurses need to have the ability to enable people in our care to be active in decision making and experts in their care. • registered nurses have the influence to enable the development of high-quality nursing practice. • the skills and attributes that university trained nurses bring to the profession are valuable.	Principle 1 (Bhaskar 2008) • That persons have the genius (Dharma) within them to flourish to their full potential . Principle 2 (McCormack and McCance 2017) • That persons who have the courage to know themselves through the exploration of their values and beliefs create the potential for human flourishing. Principle 3 (Habermas 1987; McCormack and McCance 2017) • The creation of safe spaces enables person-centred transformational learning to occur. Principle 4 (McCormack and McCance 2017; Mezirow 2000)	Principle 1 Human Flourishing (McCormack and McCance 2017) • Persons who participate in this research have innately within them the ability to flourish to their full potential both as participants and as co-researchers. Principle 2 Power within a social relationship (Habermas 1987) • Persons who participate in this research have the right to authentically participate in this research in the way that is right for them and they maintain the power to change their contribution at any point within the research process. Principle 3 Courage and Curiosity (Brown 2018)

• students are experts in their own learning journey. • when we interact with others we need to respect their expertise and value the contribution they make. • person-centred care at the point of care is achieved when nurses themselves feel cared for and valued.	• Crafting healthful relationships enables learners to move through Knowing, Doing, Being and Becoming. Principle 5 (Mezirow 2000) • Becoming is a life long journey that creates new lenses that were once unknown to us. Principle 6 (Mezirow 2000) • Critical reflection and critical dialogue are the ladders for transformational learning when learners are faced with disorientating dilemmas.	• Persons who participate in this research have the courage and curiosity to explore the layers of the relationships they develop during a clinical placement considering how this impacts on their ability to realise human flourishing. Principle 4 Transformative Learning (Mezirow 2000) • That all turbulence in clinical practice has the potential to transform into purposeful turbulence enabling student, clinical supervisor and academic staff to realise true belonging and transformative learning.

		Principle 5 Contemplation (Ungunmerr 1988) • That contemplation is embedded into the Knowing, Doing and Being as a participant and co-researcher in this PhD research.

Table 10-1 Ontological / Philosophical / Methodological Principles

My ontological and epistemological principles are summarised within the theoretical framework, 'Person-centred Transformational Learning in Clinical Practice' (see Image 10-2**Error! Reference source not found.** below) which is discussed in Taking the Road to Developing a Theoretical Framework, Chapter 6. This model demonstrates how learning occurs in clinical practice and brings together the theoretical underpinnings of how students and clinical supervisors are prepared to learn within the practice context. Further, the model shows how this learning comes together and how they experience a sense of human flourishing by gaining new learning perspectives and see the world of nursing practice in a new light in the Becoming phase. The image (see Image 10-2) below represents the initial version of this theoretical model, later in this chapter, I will share my learnings from the process of undertaking this PhD research and present the updated version of the theoretical framework.

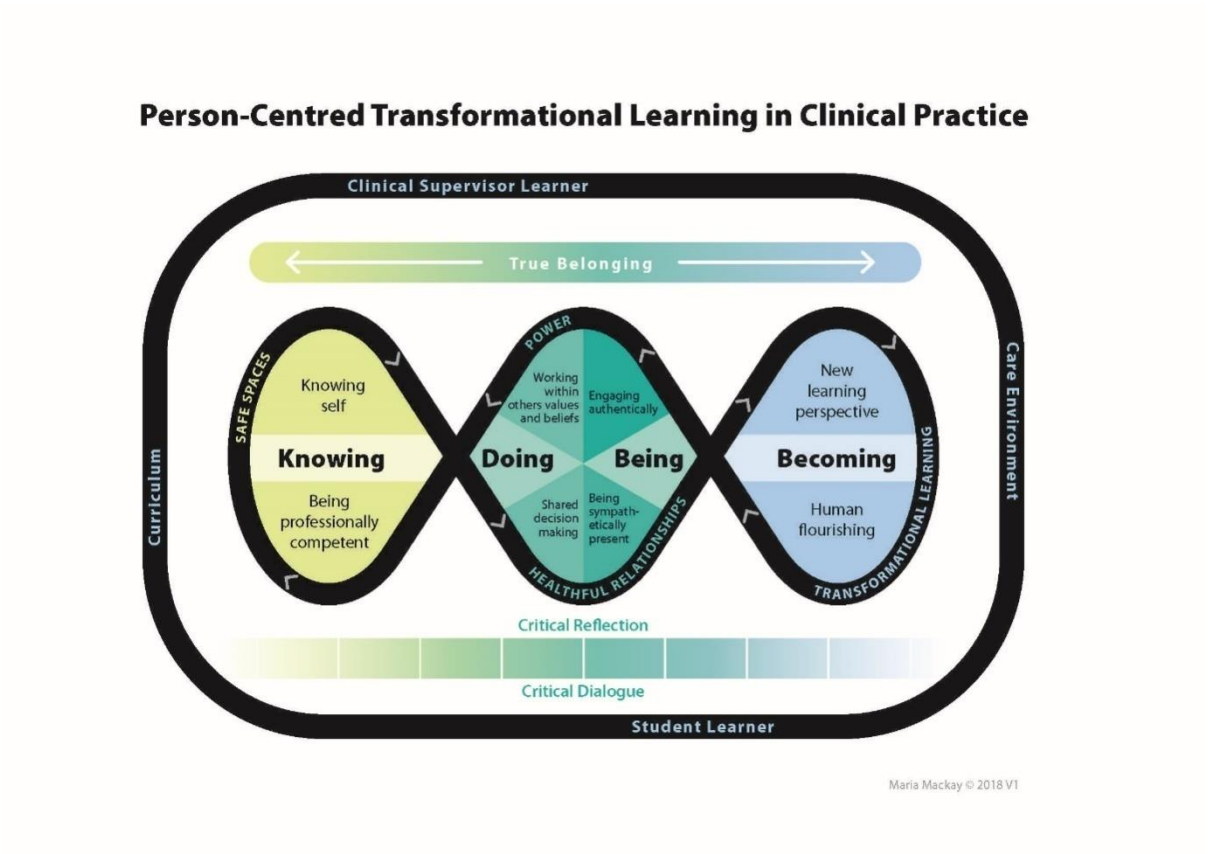


Image 10-2 Person-centred Transformational Learning in Clinical Practice V1 (2017)

The synthesis process has been influenced by my participatory Person-Centred Methodology for Exploring Healthful Relationships in Clinical Practice as shown in **Error! Reference source not found.**Image 10-3 below, which is detailed in Taking the Road to Developing a Theoretical Framework, Chapter 6. The application of this methodology in the synthesis enabled the authentic participation by participants and co-researchers. Dadirri (Ungunmerr 1988) influenced much of the research process including this synthesis, where inner deep listening and quiet still awareness was pivotal in this final stage of synthesis; it provides the gift of time and space to think, feel and reflect on the information collected and how this speaks to the research question. Dadirri also provided the space for contemplation and for all voices to be heard (Ungunmerr 1988). The gift of inner deep listening and quiet still awareness reminds me as a person-centred researcher to have patience and listen, I hold the faith that it is through this process the right discoveries will be made.

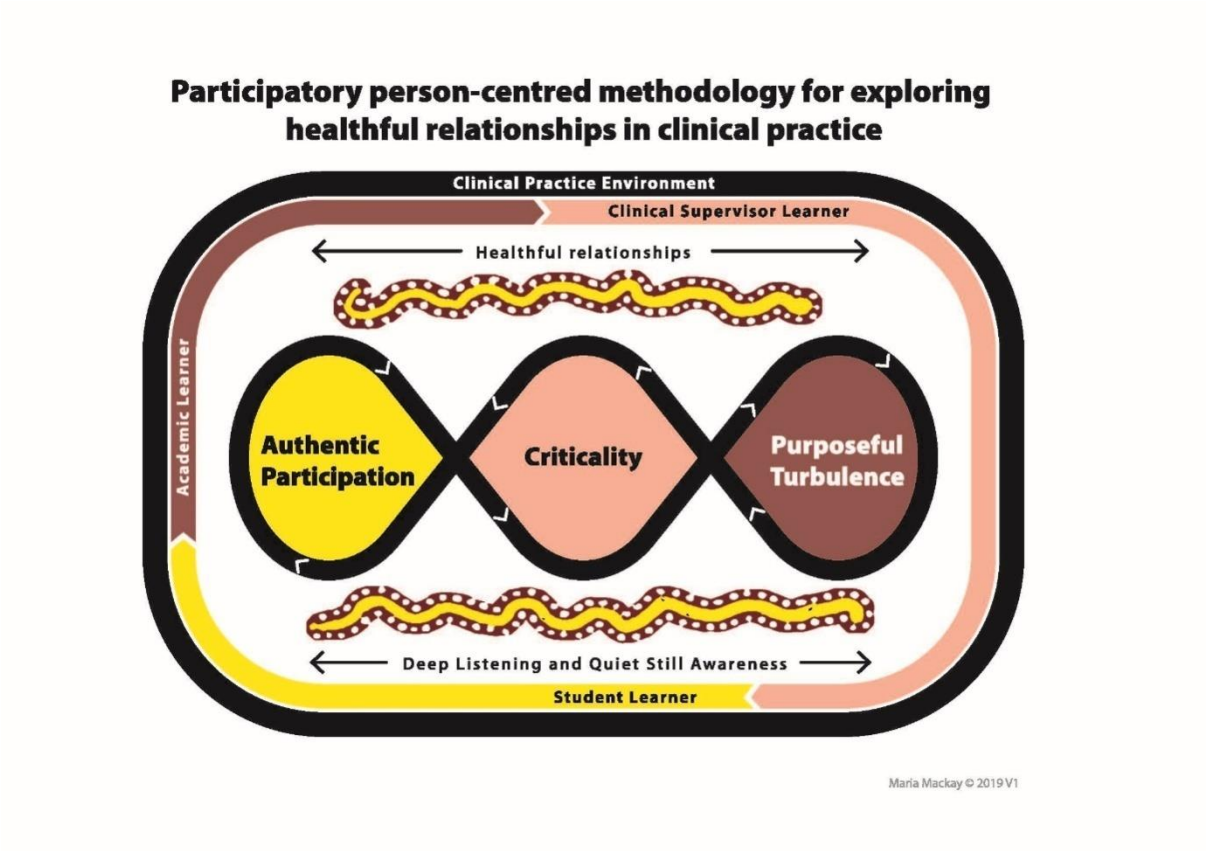


Image 10-3 Participatory Person-Centred Methodology for Exploring Healthful Relationships in Clinical Practice (2018)

Broadly speaking, I adopted four steps within the synthesis, with all steps informed by the qualitative synthesis study undertaken by McCormack et al. (2010). Within their study, McCormack et al. (2010, p. 624) analysed information across four qualitative research studies using three steps and undertook an in-depth synthesis "through a rigorous process of layered dialogues". The original McCormack et al. (2010) synthesis process had three steps and I added a fourth step; reflexivity, as I believe that consistently throughout this thesis, reflexivity has been shown to be part of the synthesis of information and a process for me to develop as a person-centred researcher. The principal researcher completed these four steps of synthesis in collaboration with the supervisory team to create a shared and comprehensive understanding of the research question. The four steps for synthesis of the information are:

1. A naïve read where all five groupings of information were read by myself.
2. The next step was a synthesis of information. Firstly, this approach was to consider the similarities and differences between the student and clinical supervisor groups, then I considered the information more globally against the research question. I then checked in with one of the supervisory team and had a critical conversation about what was emerging.
3. The third and most complex step was to 'create a shared and comprehensive understanding across the student and clinical supervisor groups of healthful relationships and its influence on Person-Centred Transformational Learning in Clinical Practice: a creative and reflective process. I again checked in with one of the supervisory team and had a critical conversation about what was emerging. I also shared this with the participants and an expert group of academics to enable ongoing critical dialogue and reflection (Mezirow 1990).
4. The final step I added to the McCormack et al. (2010) synthesis process is a reflexive process where I completed a creative and written reflection on my role in the synthesis process against my methodological principles. This formed the final dialogue I had myself against my methodological principles.

In completing this synthesis, I always remained very aware of my methodological framework/ principles to make sure I was authentic to the participants' information I was reading and exploring. At each of the four steps, I remained open to hearing, feeling and sensing any information that connected me to healthful relationships through the use of Dadirri (Ungunmerr 1988). Dadirri (Ungunmerr 1988) also enabled me to respect the authentic participation that had occurred within the collection of information and I was mindful to be respectful of the words and meanings of the publications and transcripts seeking to find both the individual voice and the collective themes that were emerging.

Critical dialogue, critical reflection and reflexivity formed my approach to criticality; this was invaluable in helping me to both raise awareness of any assumptions I may have brought to the synthesis and also to stay true to what was within the five groupings of information (Mezirow 2009). Purposeful turbulence was an essential part of the synthesis process. As I worked through the four steps, I found turbulence both in the volume and complexity of the information I was reading and trying to make sense of. The practice of Dadirri (Ungunmerr 1988) provided the conduit for me to take the time to contemplate the vast amount of complex information and have the patience to wait for the meaning to emerge when the time was right. I found that the practice of Dadirri (Ungunmerr 1988) enabled the turbulence of the information to become purposeful where new learning perspectives became evident and transformational learning occurred for me as a person-centred researcher. Dadirri (Ungunmerr 1988) moved into the space of reflexivity and this is further outlined in the following Taking a Breaks Throughout the Journey for Reflexivity Chapter 11.

The Discoveries Made Through Synthesis

The PhD research question

I am restating my PhD research question here as this is the fundamental question that I have referred to in the process of synthesis, How do healthful relationships between students and clinical supervisors influence transformational learning?

I have approached the synthesis by creating two parts to the question. I first needed to synthesise the information from student and clinical supervisor groups to define a healthful relationship. Secondly, I moved to consider how healthful relationships influence person-centred transformational learning. What is known about healthful relationships has been further explored in the Taking the Road to Developing a Theoretical Framework Chapter 6, where I have argued that very little is known about this concept and there is a need for further research and to explore healthful relationships across a variety of contexts. I believe I have added to what is known about healthful relationships and their influence on creating healthful learning cultures through the synthesis undertaken in this chapter.

What is a Healthful Relationship in Clinical Practice? – My First Set of Discoveries

I used the first three synthesis steps to create a shared understanding of what was emerging to inform me about a healthful relationship. When I undertook the initial naïve read of the information, I did this as part of a retreat I was attending. I read all five groupings of information in a setting in rural NSW Australia and used a ying-yang circle and labyrinth to engage with Dadirri (Ungunmerr 1988) and contemplate the meaning that was emerging within this reflective process (see Image 10-4 below). My initial feelings were about what the information was saying to me about how the participants had described healthful relationships. As a reminder, the context for these healthful relationships was the experience described following a 10-day clinical placement and the interviews were from both students and clinical supervisors.

Image 10-4 Reflection Using the Labyrinth (2020)

Following the retreat, I took time to re-read the five information groupings and I then looked for the similarities and differences in the two groups (students and clinical supervisors) and again took time to contemplate my learning from this. I had several conversations with a member of my supervisory team to reflect and explore what I was feeling, thinking and experiencing. She challenged me to go back to the information I had collected, and I undertook a creative theming exercise to clarify and validate the shared story or understanding that emerged from the information. I then created the following model and definitions to define crafting healthful relationships (see Image 10-5).

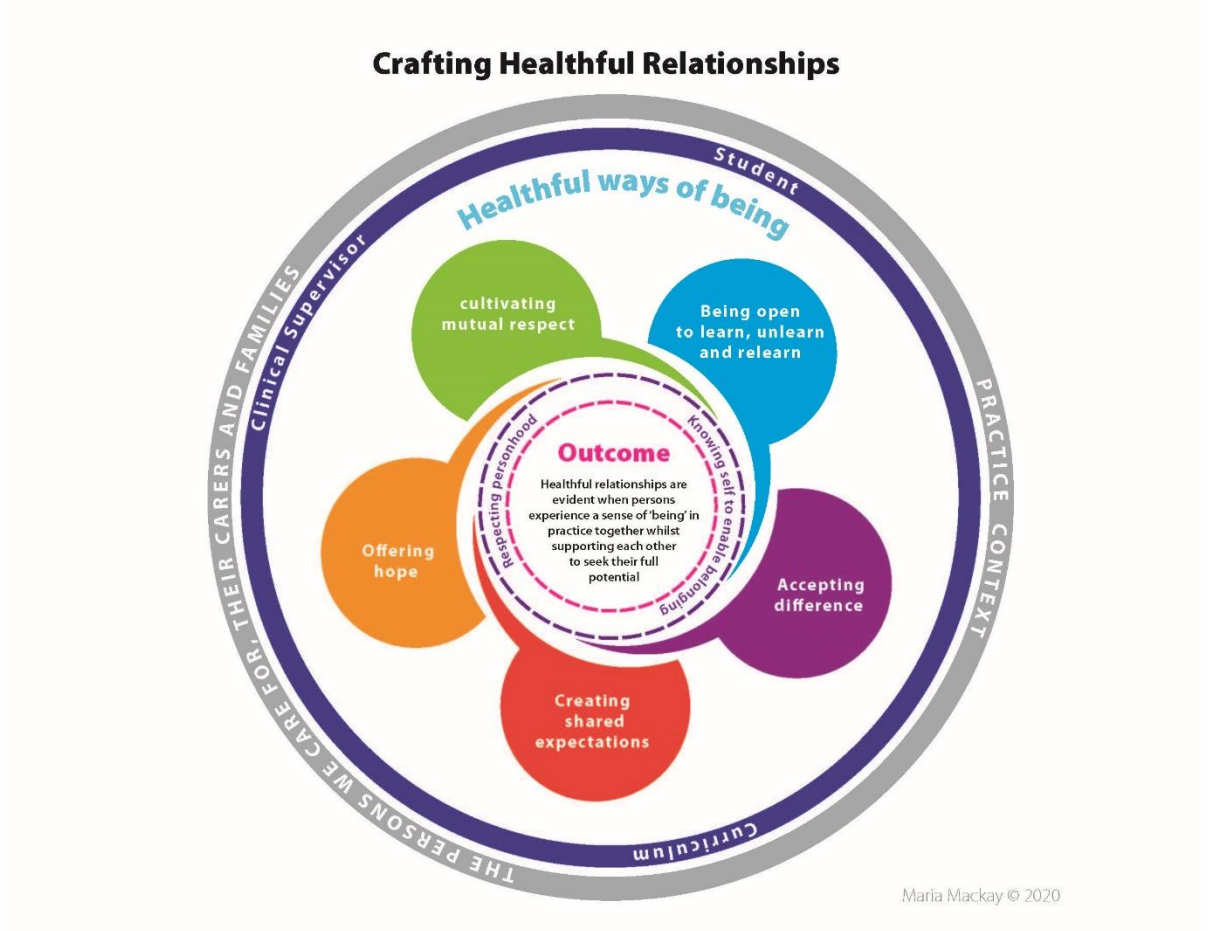


Image 10-5 Crafting Healthful Relationships (2020)

Crafting healthful relationships (see Image 10-5) is a model that I have developed and is derived from the theoretical underpinnings of person-centredness which has the ultimate outcome of creating healthful cultures (McCormack and McCance 2017). The formation of healthful relationships is enabled by the creation of mutual trust, understanding and the sharing of collective knowledge. McCance and McCormack (2017, p. 40) argue that the Person-centred Practice Framework is a mid-range theory. They state: "The Person-centred Nursing Framework has been described as a middle-range theory in that it has been derived from two abstract conceptual frameworks, comprises relatively specific concepts, and outlines relationships between the concepts." The concept of the mid-range theory is further explored in Taking the Road to Developing a Theoretical Framework, Chapter 6 and the Person-centred Practice Framework is further explored within The end of the PhD journey – Discussion,

Chapter 12, including the conceptual frameworks that have contributed to its development. I believe this PhD research's discoveries contribute to what is currently known about person-centredness, specifically healthful relationships and their influence on person-centred transformational learning in the practice context. I believe that the information collected in this PhD research supports those concepts that are currently understood to contribute to a healthful relationship (McCormack and McCance 2017). Firstly, mutual trust is strengthened in what has been discovered about cultivating mutual respect. Secondly, understanding has been supported in creating shared expectations and finally, sharing of collective knowledge has been reinforced in being open to learn, unlearn and relearn. Developing person-centred curricula and its context in practice has been described by O'Donnell et al. (2017) and the discoveries in this PhD research both support and add to the findings of developing and implementing person-centred curricula that are outlined within this chapter. I have specifically only explored the practice context and believe that I have contributed to the development of person-centred transformational approaches to learning in the practice context.

Following the above model's development, I sent it (the emergent model) out via the university email to the students and clinical supervisors for comment. I received feedback from one student and five clinical supervisors. All participants who responded could see themselves as part of the participant group and their participation in the synthesis and consequently could relate to the model. A common response was that they liked the clarity and simplicity of the model. The feedback I most valued was that the clinical supervisors could see how they could use this in their everyday practice. There were no recommended changes.

Laura (*email transcript*) a student co-researcher reflected on the model and shared with me this feedback:

> I really like the circular nature of the model, which reminds me that all of these aspects join together to create the whole that is a healthful way of being. It is an inclusive, but broad model. Very clear; not overly complicated in communicating its message.

Brenda (*email transcript*) a clinical supervisor co-researcher reflected on this model and offered this feedback:

> I do see synthesis in the model as it focuses on student and clinical supervisor relationship and the importance of respect and openness. I like that the model is focused on both the student and clinical supervisor towards the best possible experience and how important it is to have a mutual, open, honest and respectful relationship towards meeting needs of the patient and their carers as well as the student. I wouldn't change this model as it is holistic in its approach.'

I feel that both of the above quotes show the importance of how the model is inclusive of both the student and clinical supervisor voice. They also demonstrate the importance of clarity and application of the model to the reality of clinical practice.

I met with an expert group of academics and they provided feedback on the model. This group's purpose was to provide a critique of what was discovered about healthful relationships by persons who were experienced academics and have expertise in person-centred practice and/or education. Given the complexity of working within the guidelines for COVID-19, this meeting took place over Zoom on 28 July 2020 for one hour. Initially, mutual respect was described as promoting mutual respect however, this group considered that this should change to cultivating mutual respect and I agreed with this and made the change. They also recommended that I develop a set of descriptors that sit with the model and subsequently, I developed the table (see Image 10-2) below. I purposefully kept each of the definitions succinct as the consistent feedback I received was a strength of the model was its simplicity. Overall, the layers of critical dialogue and critical reflection I undertook enabled me, as a person-centred researcher, to feel confident that I had represented the voice of the student and clinical supervisor participants and co-researchers in a way that had meaning for them (Mezirow 2009). The words below come from the process of synthesis that occurred by bringing together the voices of both groups of participants and co-researchers. They have been validated by the student and clinical supervisor co-researcher groups.

	Description
The practice context	The context in which healthcare is experienced.
The persons we care for, their carers and families	Creating relationships that are inclusive and where diversity is acknowledged and respected.
Clinical Supervisor, student	Acknowledging shared leadership and responsibility to learn from each other within the practice context
Curriculum	Creating curricula underpinned with person-centred transformational learning
Knowing Self to enable belonging	Creating relationships that challenge what is known about oneself to enable persons to have the courage to be authentic in their actions and behaviours
Respecting personhood	Creating relationships that see the person behind the title
Cultivating mutual respect	Creating relationships that cultivate trust and respect by being authentic and inclusive of individuality
Open to learn, unlearn and relearn	Create relationships where persons have a learner rather than an expert lens
Accepting difference	Creating relationships that are vulnerable and brave and encourage persons to optimise difference
Creating shared expectations	Create relationships that move toward discomfort by co-creating shared ways of Doing and Being with each other
Offering hope	Create relationships where opportunities are experienced as a gift and language is hopeful, future-focused and suggests issues are temporary

Table 10-2 Crafting Healthful Relationships Definitions

The outcome thus is that a healthful relationship is evident when persons experience a sense of being, in practice together, whilst supporting each other to seek their full potential.

I will now explore each of the parts of my emergent model and demonstrate how they spoke to me using the voice of the participants and co-researchers.

The outer circle

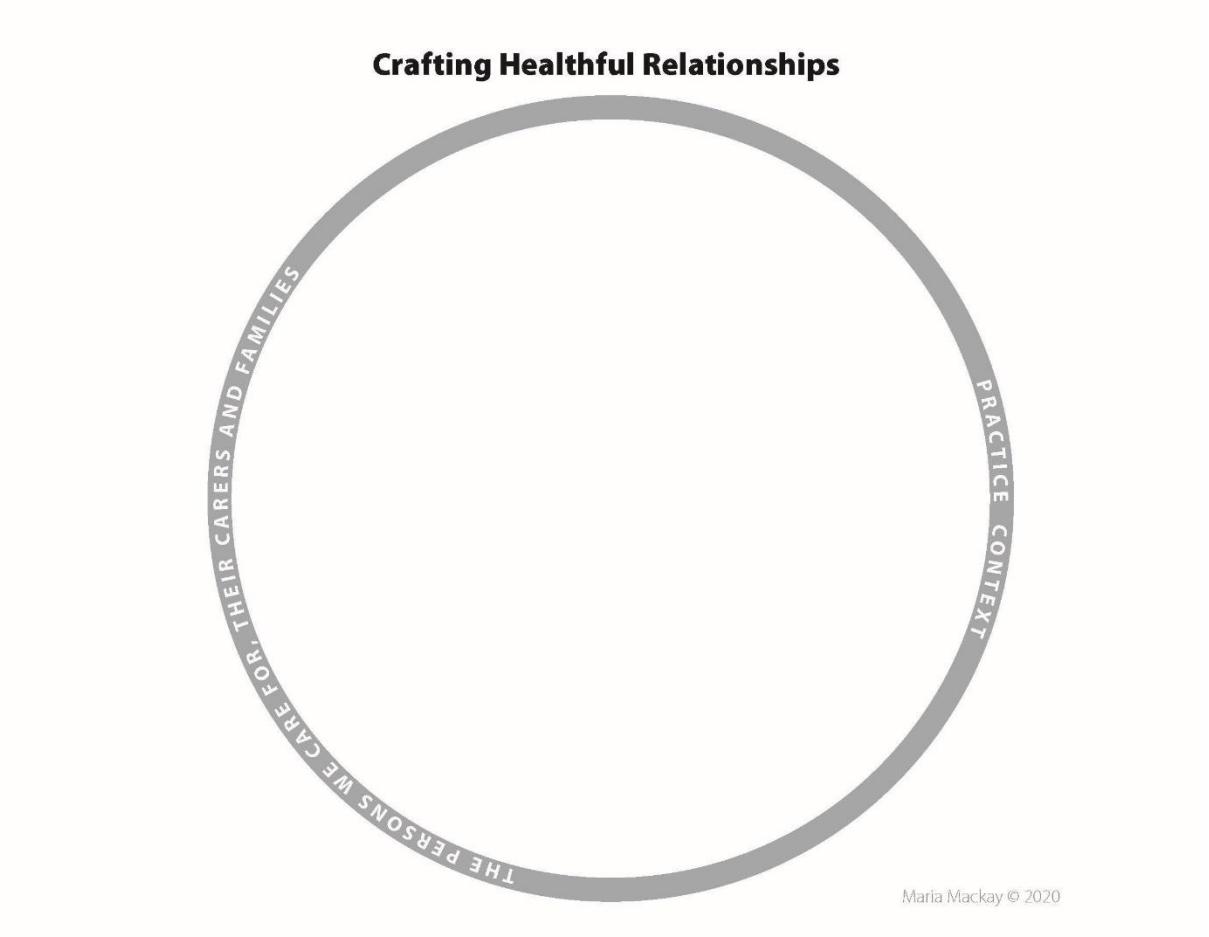


Image 10-6 Crafting Healthful Relationships - Outer Circle (2020)

The outer circle of the model (see Image 10-6) is comprised of the practice context, defined as the context where healthcare is experienced. The persons we care for includes carers and family and I define this as creating relationships that are inclusive with diversity acknowledged and respected. In this outer circle, I acknowledge the link between person-centred pre-registration curricula and students embodying person-centred practice. The clinical supervisor's voice was not as prominent in the information collected as that of the students when referring to the practice context. I find this interesting. I am aware that I hold the assumption that the clinical supervisors were focused on caring for the students, whilst students were more focused on caring for persons in the context of healthcare. From reading the student story, I understood their words to be about creating relationships with the persons we care for, which helps

students to see the person behind the patient. Temika (part one round two, interview transcript) a student participant described this as:

> I met a young man who's, similar to my age who had brain surgery, and that was so fascinating to me. I really got to know him and find out his story. I don't think I'll forget him anytime soon. Positive note, he was discharged. So that's a good thing. But …, just the relationships that I made with the people that I met was quite cool. Quite memorable actually.

Alissa (*part one round two, interview transcript*) another student participant described her connection with the persons she cared for as something she realised over time:

> I always just thought I would be fine .., I, I treat everyone equally… but ..., there was one person in particular that I found it really hard to, .. get to know him or be able to do anything with him because I don't know, he was nonverbal ..., I didn't know how to communicate with him. I didn't know how to approach him until the last week, where I finally found that, that groove with him where I, I had, I the courage to just be able to go in there and go, he's just another, he's just like everyone else. Talk to him and yeah, and then I found that he is just like everyone else.

I felt both these quotes demonstrated that students respected the practice context as a place for connecting with others and where the reality of practice enables them to embody their way of being with the people they care for.

The blue circle

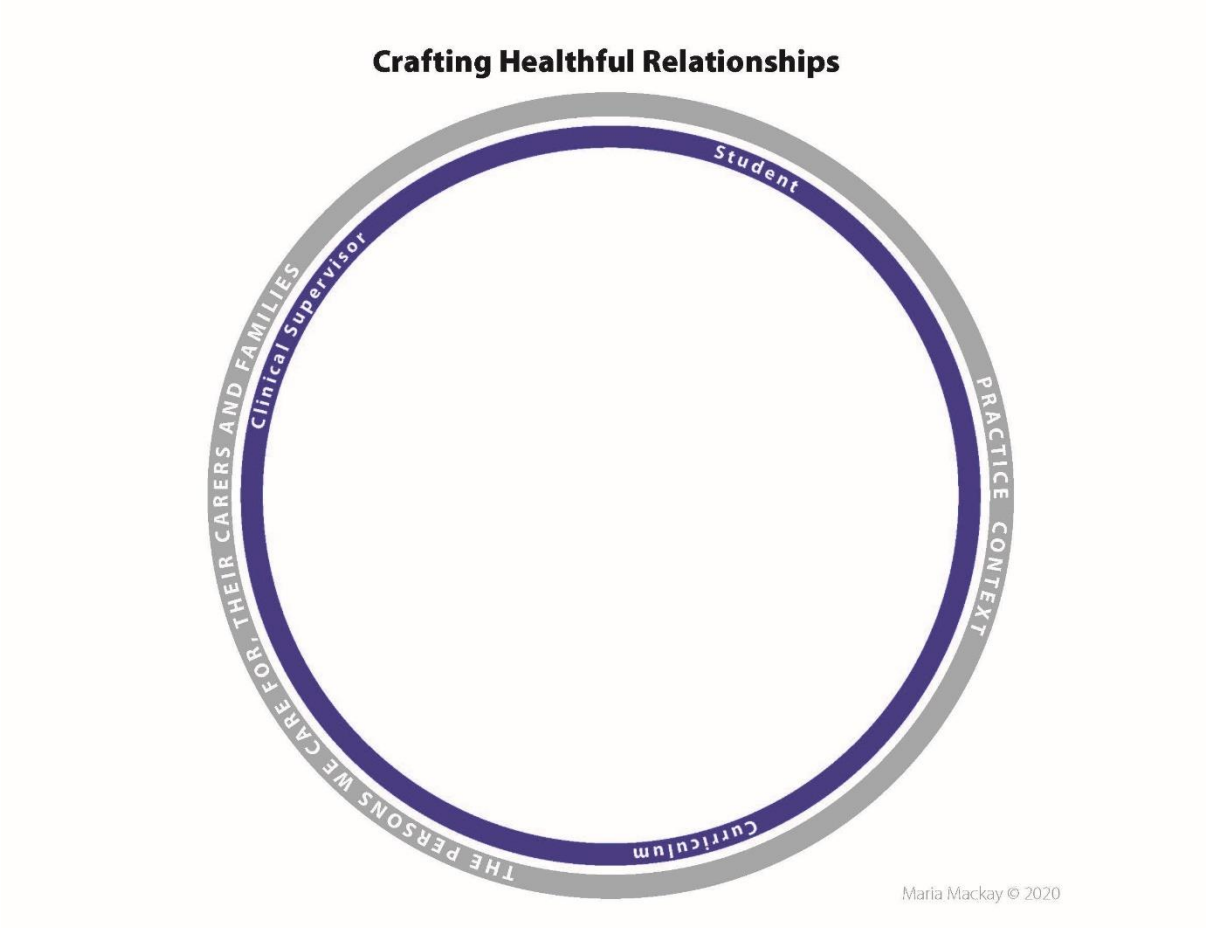


Image 10-7 Crafting Healthful Relationships - Blue Circle (2020)

The blue circle (see Image 10-7) represents that students and clinical supervisors both have a role in crafting healthful relationships and that this relationship sits within the context of the pre-registration nursing curricula. I believe the information demonstrated that healthful relationships between students and clinical supervisors requires shared leadership and responsibility to learn from each other within the practice context. The emphasis on curricula refers to creating curricula that are underpinned with person-centred transformational learning (O'Donnell et al. 2017, Mackay et al. 2021). These ideas can be seen in the feedback from the student and clinical supervisor co-researchers where they demonstrated the need for both to be authentically present and to have a role in crafting healthful relationships.

Healthful Ways of Being

Healthful ways of being, as a phrase, was developed in the process of synthesis as a way of representing the shared understanding of what is required to be considered when creating and maintaining a healthful relationship between students and clinical supervisors. There are five healthful ways of being and I have tried to represent each of them with movement, as there is no specific order or level of importance in the descriptor, rather they should be fluid and applied to each relationship as necessary.

1. Cultivating mutual respect

Image 10-8 Crafting Healthful Relationships - Cultivating Mutual Respect (2020)

I define cultivating mutual respect as creating relationships that cultivate trust and respect by being authentic and embracing individuality (see Image 10-8). Brene Brown (2010) talks about trust being fostered in the small acts we do for each other; I believe this is also evident in the voices of the participants where mutual respect is cultivated

in the small acts we do for and with each other. The small acts that create trust are cumulative in developing and maintaining a relationship. Importantly, moving forward in the relationship, students and clinical supervisors need to remain mindful that these small acts are not diminished within the complexity of practice rather they are added to, ensuring that the relationship remains trusting. Sharing parts of your personal story helps to build trust, respect and creates relationships with others.

Alissa (*part one round two, interview transcript*) a student participant revealed how sharing personal stories helps connections to be made:

> ...we met as a group with the Clinical Supervisor. It went really well. It was nice to share our stories. It was nice to have her facilitate a meeting. She was calming, reassuring to all the group. And it was nice to see the way she interacts with everyone.

Wendy (*part one round one, interview transcript*), another student participant also disclosed the small things that made a difference in her relationship with her clinical supervisors as: "… then she took us up to the wards and then she, you know um, talked to the nurse unit manager and, you know she just made us feel comfortable on the very first day."

From the clinical supervisor perspective, Marylou (*part one round one, interview transcript*), a clinical supervisor participant shared how making fun activities where everyone shares things about themselves helps everyone in the group (both clinical supervisor and students) to know each other better. She stated:

> So the surprise was, this student that I was with was shy while other students are really open, they like the activity, … I told 15 fun facts about myself because they just rolled a lot of tissue paper in their hand and we all shared fun facts about ourselves. But this particular student that I had yesterday, … which I had so much admiration because she was so open to talk about her experience and her maturity. She wasn't able to open up until after this activity.

Authenticity formed another part of the shared story for both groups of participants and co-researchers. Authenticity is a daily practice and choice in how we live our lives and shows up in our relationships with others, where we aim to live with the courage to be authentic to our values rather than what we believe is expected from us (Brown

2010). Authenticity was considered to help cultivate respect for self and others and ultimately mutual respect.

Loreen (*part two, information synthesis workshop transcript*), a student co-researcher spoke about mutual respect in this way: “I think that to have a helpful relationship you have to have respect. Self-respect, respect for others, mutual respect.”

Ashley (*part one, round two, interview transcript*), a clinical supervisor participant spoke about the courage students require to share their fears and how this creates mutual respect:

> Today a student approached me to let me know of her fears on placement... She'd transferred from another state. It felt really lovely to be trusted with fears, and as the conversation with lots of reassurance progressed, it was nice to see the facial expression turn from frowns, and worried, and furrowed brows, and that kind of thing, to smiles. I felt good that I could help her. So that made me feel valued, trusted and useful in my role.

2. Being open to learn, unlearn and relearn

Image 10-9 Crafting Healthful Relationships - Being Open to Learn, Unlearn and Relearn (2020)

Being open to learn, unlearn and relearn was the healthful way of being that was discovered by me last of all (see Image 10-9). It is something that was always there however I needed to sit with silence, to listen and be in relationship with the information collected to discover this from the voices of the participants and co-researchers. I define this as creating relationships where persons have a learner rather than the expert lens. Therefore the realisation of this was always going to be more challenging for the clinical supervisors, who feel they need to be an expert in their role rather than students who are more open to learning.

Loreen (*part two, information synthesis workshop transcript*), a student co-researcher considered the difference between a learning and expert lens in her clinical supervisor in referring to learning and teaching:

> wanting to learn and on the opposite side, wanting to teach. Somebody, I think in one of the transcripts said that specifically, ... yes, that's absolutely true. If you want to learn, you're going to get something out of it. If I don't want to teach, you're going to get what you give.

In our clinical supervisor part two synthesis workshop, Kathy (*part two, information synthesis workshop transcript*), a clinical supervisor co-researcher made the realisation that the concept of learning, unlearning and relearning was also for them as clinical supervisors not just for students. When we were exploring holding space, she stated: "The holding space thing, we're talking about that for the students, aren't we? Was that students or for us?"

At this point, Kathy realised and helped others to realise that learning was possible for clinical supervisors as much as for the students. They needed to hold space for each other to learn, unlearn and relearn and show their vulnerability in being open to challenge themselves to remove their expert lens, even though in their role they are employed for their expertise. Having expertise and having an expert lens is very different; the expert lens stops growth. The concept of expert versus expertise will be further explored at The end of the PhD journey – Discussion, Chapter 12.

3. Accepting difference

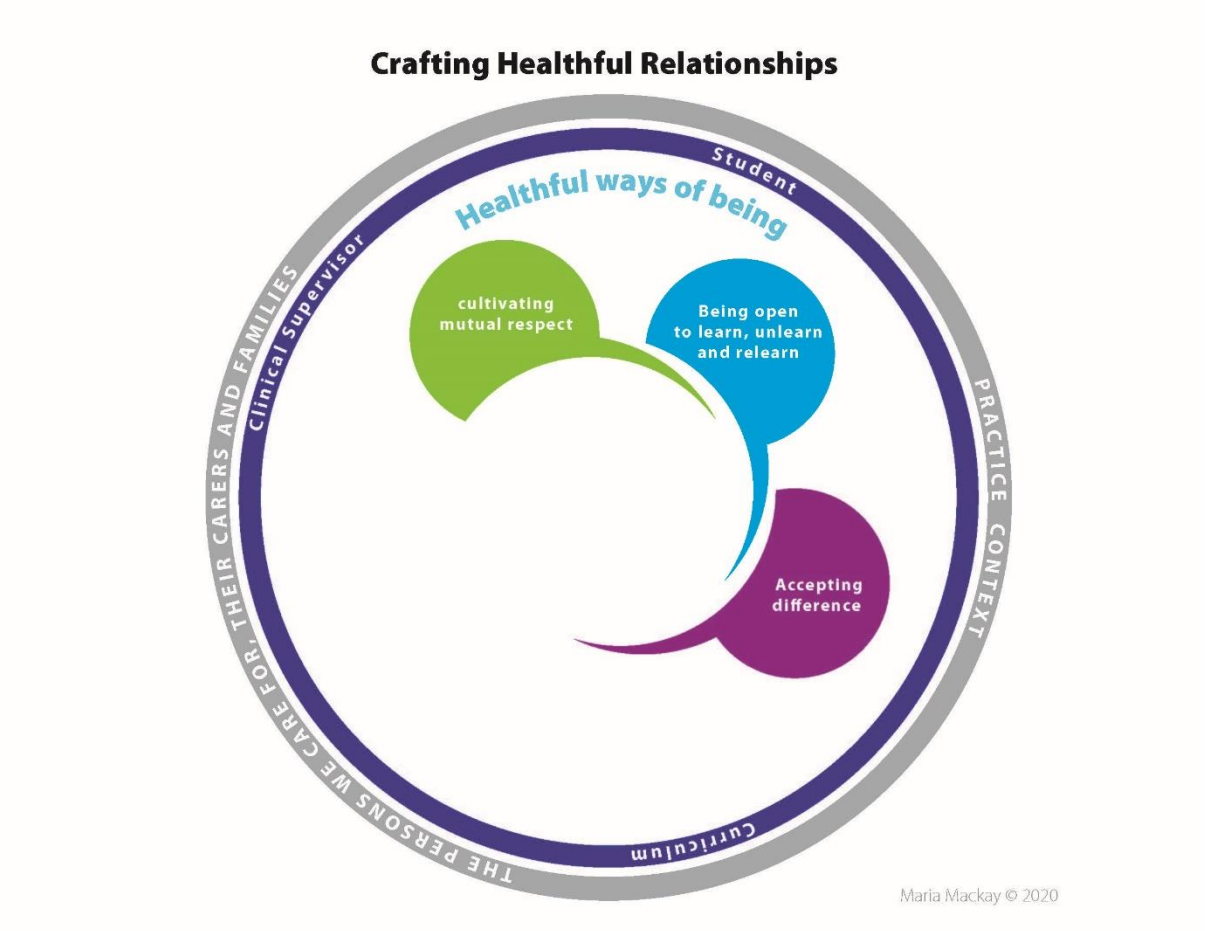


Image 10-10 Crafting Healthful Relationships - Accepting Difference (2020)

Healthful relationships have embedded acceptance of difference, however, the challenge first is to acknowledge that the lens we wear at times masks difference (see Image 10-10). Accepting difference is closely related to respecting personhood which I explore later, as I unpack this model within this chapter. Accepting difference is defined as creating relationships that are vulnerable and brave and encourage persons to optimise difference.

Kylie (*part one, round two, information synthesis workshop transcript*) a student co-researcher commented on difference: “Everybody has acknowledged that there were good parts and not so good parts, good stories not so good story, but that makes a whole.”

Loreen (*part two, information synthesis workshop transcript*) a student co-researcher summarises the voices of the synthesis with student co-researcher workshop by stating:

> Respecting difference and also ..., respecting each other's differences. Because you can do that in two ways, you can respect their differences and have literally nothing to do with them because it's too different and you're just like, It's easier if I walk away ..., or you really have to make something of it. And being truthful, in that sense … is really going to make a difference. I respect your rights to have an opinion, but I absolutely don't have to respect what that opinion is.

Ngaire (*part two, information synthesis workshop transcript*) a clinical supervisor co-researcher summarised the voices of the clinical supervisors by stating: "I would say students and being mindful of the student's background … Being mindful so to get them involved in communication …Being flexible."

The issues that have a bearing on accepting difference were presented as judgments and the assumptions 'we' hold; some are known to us and some are unknown. I suggest, we all have a role to be brave and to have the courage to look inside an be honest about our assumptions.

Wendy (*part one, round one, interview transcript*) a student participant shared her thoughts about accepting difference with her supervisor and how she needed to have a role in creating relationship: "I've tried to work with the clinical supervisor...to speak with her and try to understand her and her position and ask her questions and…engage with her better."

4. Creating shared expectations

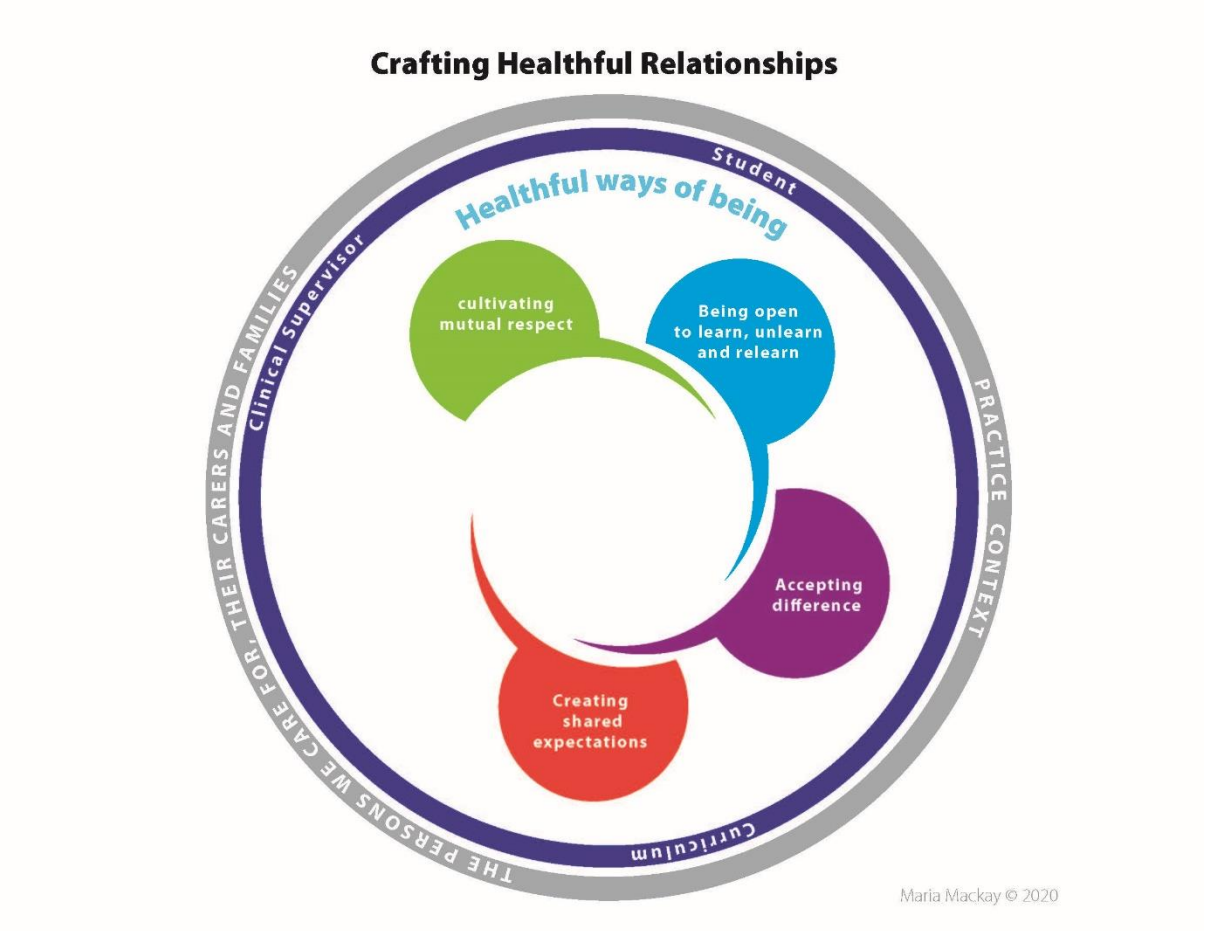


Image 10-11 Crafting Healthful Relationships - Creating Shared Expectations (2020)

Shared expectations are defined as creating relationships that move toward discomfort by co-creating shared ways of Doing and Being with each other (see Image 10-11). Enabling each other's voice was shown to be important in creating shared expectations whilst also ensuring that the hard things were discussed and not avoided. Clarity was another important aspect, creating shared expectations needs to be clear for all involved and expectations need to be followed through. When moving towards discomfort and uncomfortable conversations, we need to consider that power over can be perceived on both sides of a relationship. Listening and hearing each other's viewpoint is important along with regular check-ins to ensure the shared expectations are being adhered to.

Within the information collection, students spoke about times when they were unsure of the expectations of them and their clinical supervisor and this led to feelings of confusion and frustration. This was summarised by Belinda (*part two, information synthesis workshop transcript*) in a student co-researcher synthesis workshop in part two as: "… having a good understanding exactly of your (and others) expectations. Because I think a lot of people looked like that were very confused by their own emotions."

Percy (*part one, round two, interview transcript*) a clinical supervisor participant spoke about a moment where she realised that she had not created shared expectations as:

> I wasn't happy with that because initially, I felt there was no excuse, there was no reason at all why he was not filling it in and then later on I realised that they just needed a little bit of more support.

The healthful ways of being are where both students and clinical supervisors worry if they move towards discomfort and present challenges, they believe will impact the relationship negatively, however, both also expressed that by not doing this they remain in a state of discomfort and confusion.

5. Offering hope

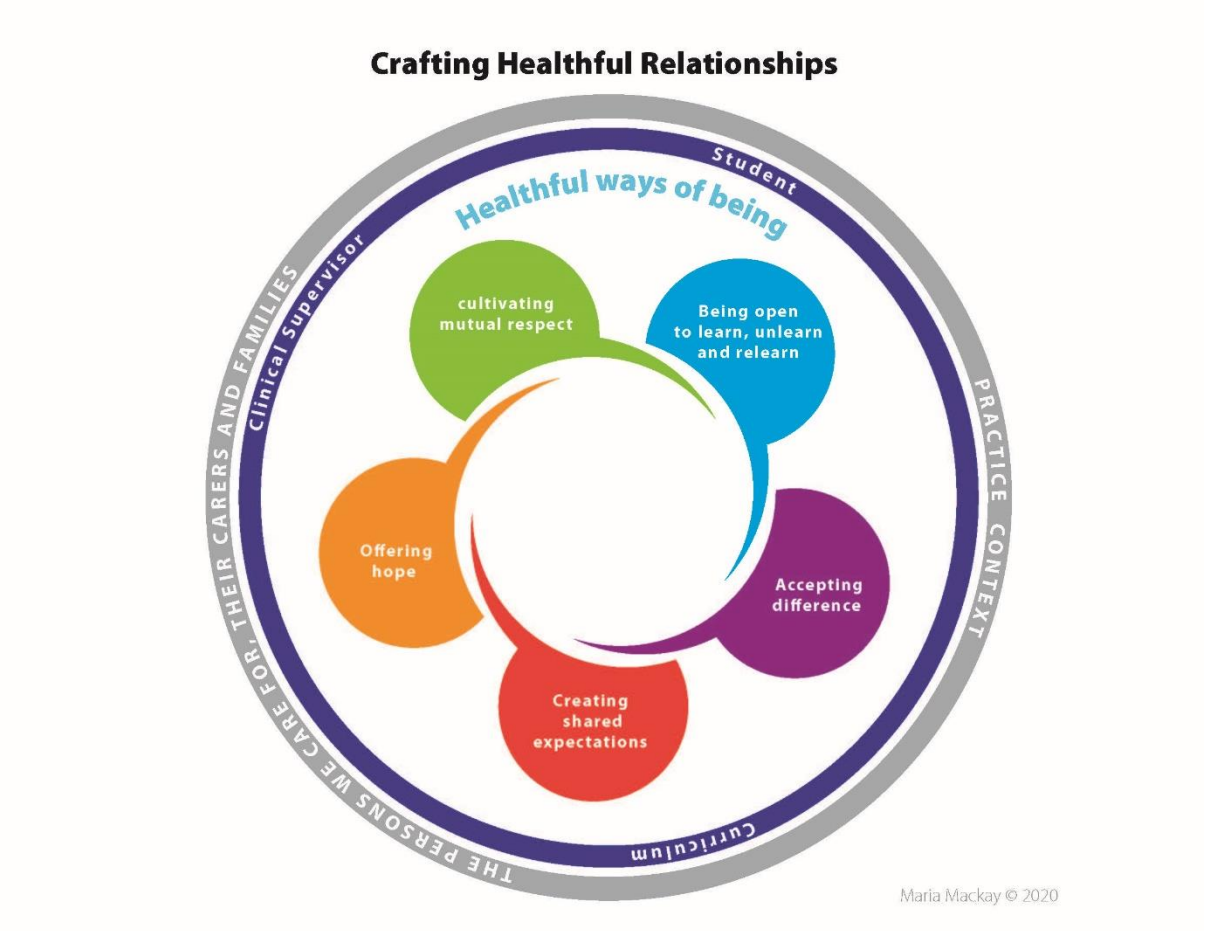


Image 10-12 Crafting Healthful Relationships - Offering Hope (2020)

Offering hope is an important healthful way of being with others when crafting healthful relationships (see Image 10-12). Offering hope needs to be on both sides of the relationship. For students, this was acknowledged, however, it was stronger in the voice of clinical supervisors. Offering hope is defined as creating relationships where opportunities are experienced as a gift and language is hopeful, future-focused and suggests issues are temporary. Offering hope can also be related to Habermas's (1987) concept of offering a rational alternative and where we as persons feel hopeful through considering an alternative, that gives us hope. Students and supervisors have a role through their critical conversations and critical reflection to provide an alternate perspective and be open to hearing each other's alternatives. The concept of rational alternatives has been fully explored at The end of the PhD journey – Discussion Chapter 12.

For the student participants, hope was in two categories. The first was in the form of opening up opportunities.

Emily (*part one, round two, interview transcript*) a student participant spoke about being offered hope in the following way:

> My clinical supervisor encouraged me to keep striving to take on more. Then that day he said to try and do a handover of my own, like the afternoon handover with my buddy registered nurse. But just with her witnessing it and adding anything if I missed anything. I was like, "I'm too exhausted to try and keep mental notes, but I did it and it was great.

Secondly, Temika (*part one, round two, interview transcript*) another student participant considered being offered hope in feedback from her clinical supervisor in the quote:

> I was given some wonderful compliments and some wonderful feedback from her. ... So I spent the whole day very happy, feeling very happy about myself'.

Offering hope for the clinical supervisor participants was centred on how they used language and interacted with students to offer hope indirectly. The clinical supervisors themselves felt hopeful when they saw and felt students progressing during their clinical placement. The concept of vulnerability was highlighted as an aspect of offering hope in that we need to be open to give and receive feedback authentically to enable offering hope to craft our relationships with others.

Yvonne (*part one, round two, interview transcript*) a clinical supervisor participant describes offering hope as her hope that tomorrow is another day where positive things may happen. Clinical supervisors need to be mindful of language especially tone and body language, as this is interpreted/misinterpreted by students and may affect their ability to offer hope:

> I feel like a smile. Happy, and I felt content because I had a good day on the first day. These emotions that I put in before, it was like a little mirror. Like the students were very scared, anxious, and they make me feel in some way, like this as well, but the next day was like, "Hey, it's fine, it's okay." Refresh again, and happy again.

In a conversation during the information collection synthesis workshop in part one, round two, Ashley and Pat (*part one, round two, information synthesis workshop transcript*) as co-researchers explore how offering hope with honesty leads to showing our vulnerability with others:

Ashley:
“I think we have to be hopeful, open and honest with them. Let them know that we are traveling this journey with them.”

Pat:
“That's the **vulnerability** side of it and I agree very much with that.”

Fundamentals

1. Knowing self to enable belonging
2. Respecting belonging

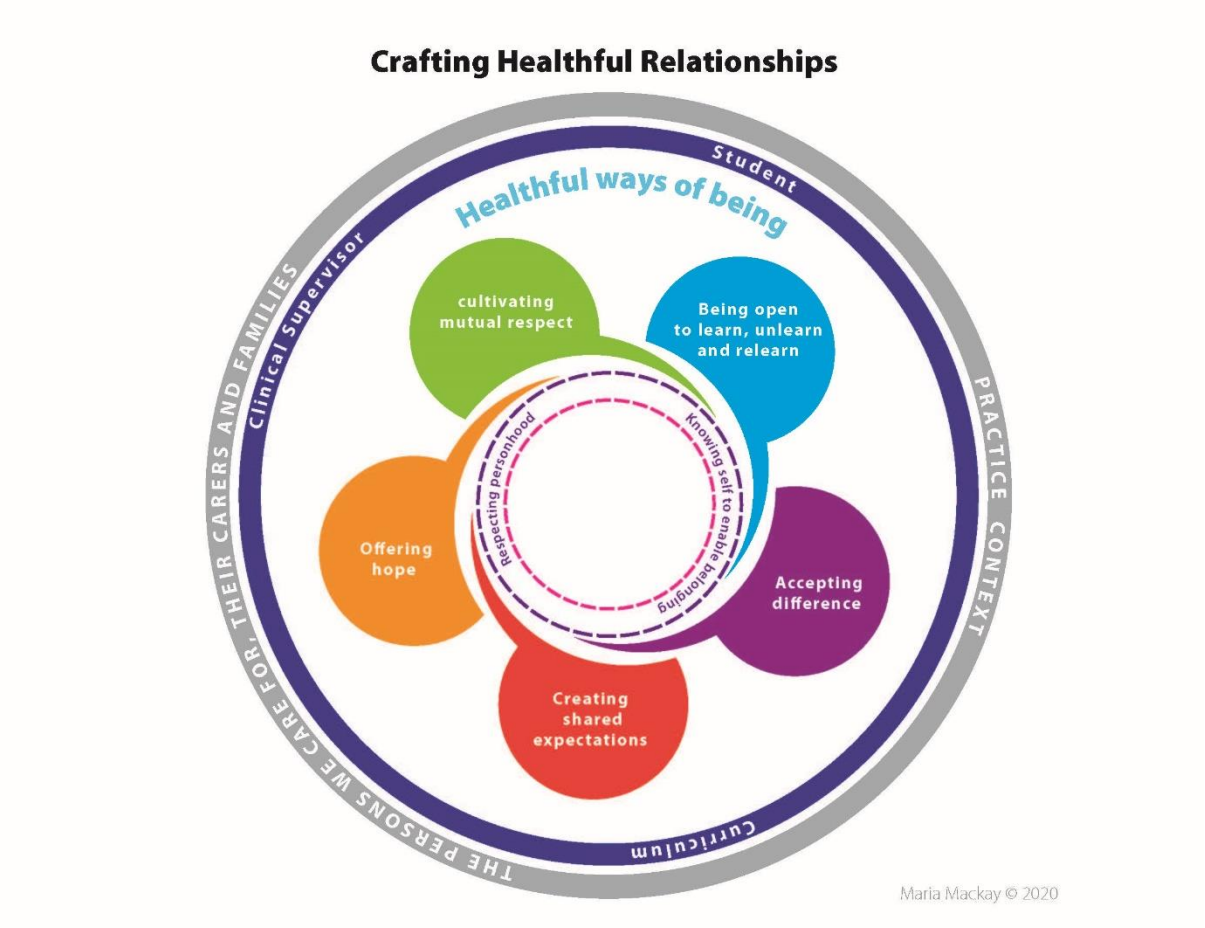


Image 10-13 Crafting Healthful Relationships - Fundamentals (2020)

I have defined knowing self to enable belonging as creating relationships that challenge what is known about oneself to enable persons to have the courage to be their authentic in their actions and behaviours. Respecting personhood was defined as creating relationships that see the person behind the title. Both these concepts emerged as fundamental in crafting healthful relationships and have intentionally been placed around the outcome of crafting healthful relationships (see Image 10-13). These fundamentals relate to each other in that to see the person behind the title of a patient, student, clinical supervisor, nurse manager, registered nurse etcetera; you need to have the courage to be your authentic self and not just follow along and fit in when your

values are being challenged and the person is not foremost in our care and relationships with others.

I have considered belonging from three perspectives in Taking the Road to Developing a Theoretical Framework, Chapter 6. Firstly, belonging from the behaviourist perspective of fitting in (Levett-Jones and Lathlean 2009), secondly from a social science perspective, true-belonging (Brown 2010) and finally from the perspective of freedom to be authentic to yourself (Angelou and Elliot 1989). I believe the information collected within this PhD research supports my claim that belonging from a person-centred perspective is related to understanding self, authenticity, and values through knowing self to enable belonging from a freedom perspective (Angelou and Elliot 1989). Angelou in a conversation in 1973 with Bill Moyers (Angelou and Elliot 1989, p.22) discusses that the freedom that comes from belonging to yourself also comes with great sacrifice and also great reward. She describes belonging as: '*you are only free when you realize you belong no place – you belong every place – no place at all. The price is high. The reward is great*.' Maya Angelou was an African American woman who is a renowned writer and poet and is argued by Permatasari (2016) to write from a feminist perspective and be one of America's greatest literary influences. I believe giving voice to a Black African American Woman's writing in my research is important as this integrates a decolonised view into the development of learning and teaching resources. The concepts of decolonising curricula will be further explored within The end of the PhD journey - Discussion, Chapter 12 of this thesis. This also aligns with my ontological principles in Discovering Me and My Ontological Values, Chapter 3 and my way of understanding the world as a first nation's person. Decolonising as a perspective relates to Aboriginal people and this part of the Dadirri poem speaks to the impact of this on creating relationships:

> Our people are used to the struggle and the long waiting. We still wait for the white people to understand us better. We ourselves have spent many years learning about white man's ways; we have learnt to speak white man's language; we have listened to what he had to say. This learning and listening should go both ways. We would like people in Australia to take time and listen to us. We are hoping people will come closer. We keep on longing for the things we have always hoped for, respect and understanding.

Loreen (*part one, round one, interview transcript*) a student participant considered the challenge of knowing self to enable belonging in her interview as:

> the biggest thing, which is going to go in my recollection, is ... actually reflecting on our own values and our own beliefs. I wrote my values .... in class when we had spoken about it with our prerequisites and, you know in my heart I want to believe that they're my values that I would just naturally give, but then I think sometimes you're confronted with things you've never been confronted with, ... (your response) can be changed.

I perceive the relationship between belonging and personhood is in seeing the person for their uniqueness and appreciating each person for their humanity. In my Moving Along the Road to a Philosophical Exploration of Person, Personhood and Person-Centredness Chapter 4, I have argued that persons have a right to determine their own personhood. In the reality of practice, this at times may pose challenges as seeing the person behind the title means that we need to accept and unravel how we react and respond to those who are different to ourselves.

Wendy (*part one, round one, interview transcript*) a student participant in her interview tried to see the person behind the title when engaging with her clinical supervisor: "trying to engage with her. And just try to understand her as a person and, I felt that .., the relationship would be a lot better."

Hollie (*part one, round one, information synthesis workshop transcript*) a student co-researcher after reviewing all of the student interviews for round one felt courage was required to seek the person and stay authentic to their values in stating: "I feel like all of us have been able to just draw from our inner strengths as people to see the other people for what they were and to just move beyond it."

Laura (*part one, round one, information synthesis workshop transcript*), a student co-researcher, summarised the student perspective by stating: "people realised that they needed to really look inward in order to lookout. Which is literally the whole point."

Clinical supervisors as participants felt they also gained insight into the person behind the title in getting to know students, Ashley (*part one, round one, interview transcript*) a clinical supervisor participant shared:

> I was, so he asked me to come to the Emergency Department (as a student was there for treatment), ... To be honest, I assumed somehow a body exposure or someone coughed in his eye or something, ... He was very grateful that I sat with him and it gave me a lovely chance to learn more about him as a person because once everything changes somehow, you're not placement anymore, you're personnel.

They also felt the emoji helped them to consider themselves in their role and their responses when challenged, Ngaire (*part one, round two, interview transcript*), a clinical supervisor participant, stated: “The emoji, they helped me understand my feelings. Why I felt a little like that and how I should have reacted in any particular situation. Having the emoji does help.”

Outcome

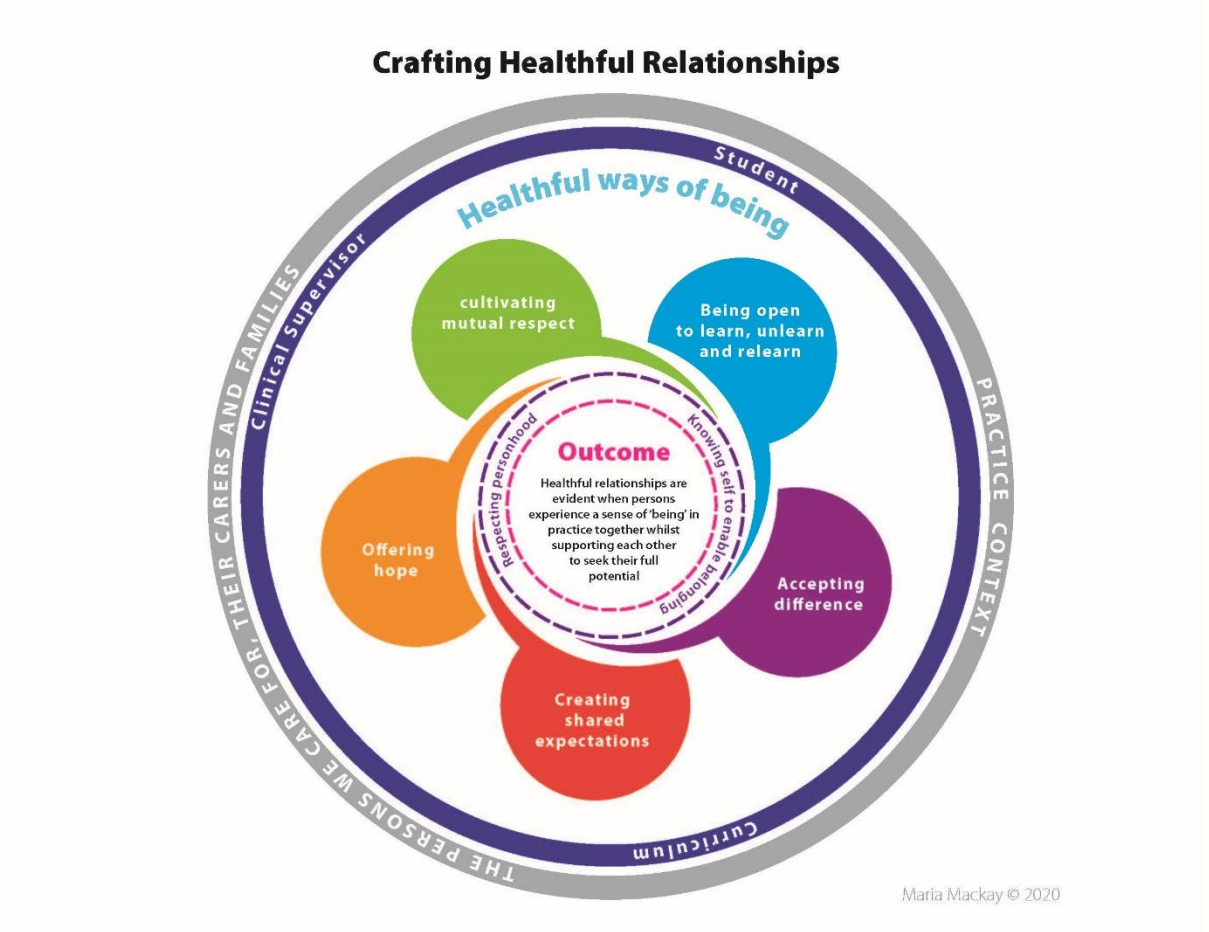


Image 10-14 Crafting Healthful Relationships - Outcome (2020)

Overall, synthesising all the learning and the wordles created has led to a new/emergent understanding of crafting healthful relationships in the context of student and clinical supervisor relationships (see Image 10-14). I believe *healthful relationships are evident when persons* (students and clinical supervisors) *experience a sense of being in practice together whilst supporting each other to seek their full potential*.

Wendy (*part one, round one, interview transcript*), a student participant describes individual responsibility to find our inner balance and seek our own full potential in her comment:

> I feel like, ... it is up to the individual to remain balanced and that there's going to be problems like cracks on the fishbowl. And we have to use our training and stay centred and get through the difficulties as we can.

Clinical supervisor participants recognised that the relationship impacts on each individual's ability to achieve inner balance. Genoveva (*part one, round two, interview transcript*) a clinical supervisor participant, relates her experience and emotions to nurturing plants and the joy we feel in seeing plants not just survive but flourish:

> being with them full, closely, observing them and giving feedback and receiving feedback and receiving feedback from the staff, ... It's more like, "Look." I'm somebody, I'll give you an analogy. I will make an analogy. I love plants. I love flowers. Growing of plants, but every single day looking careful, how they grow, is anything wrong. This is how I am with the students, I'm very careful every single day to see how they are mentally, physically, professionally prepared for the day, for the journey and it does create a relationship between us too. A bond with the students.

How do Healthful Relationships Influence Person-centred Transformational Learning in Clinical Practice? - My Second Set of Discoveries

As previously stated, part two within the information collection considered how the information synthesised by participants and co-researchers addressed the question of How do healthful relationships between students and clinical supervisors influence person-centred transformational learning? For this second set of discoveries, in part two the co-researchers in their separate groups considered what they now understood a healthful relationship to be (from the initial part of the workshop) and explored how healthful relationship influence transformational learning in clinical practice. The part two co-researchers considered the concepts of Knowing, Doing, Being and Becoming from the theoretical framework, 'Person-centred Transformational Learning in Clinical Practice' below (see Image 10-15).

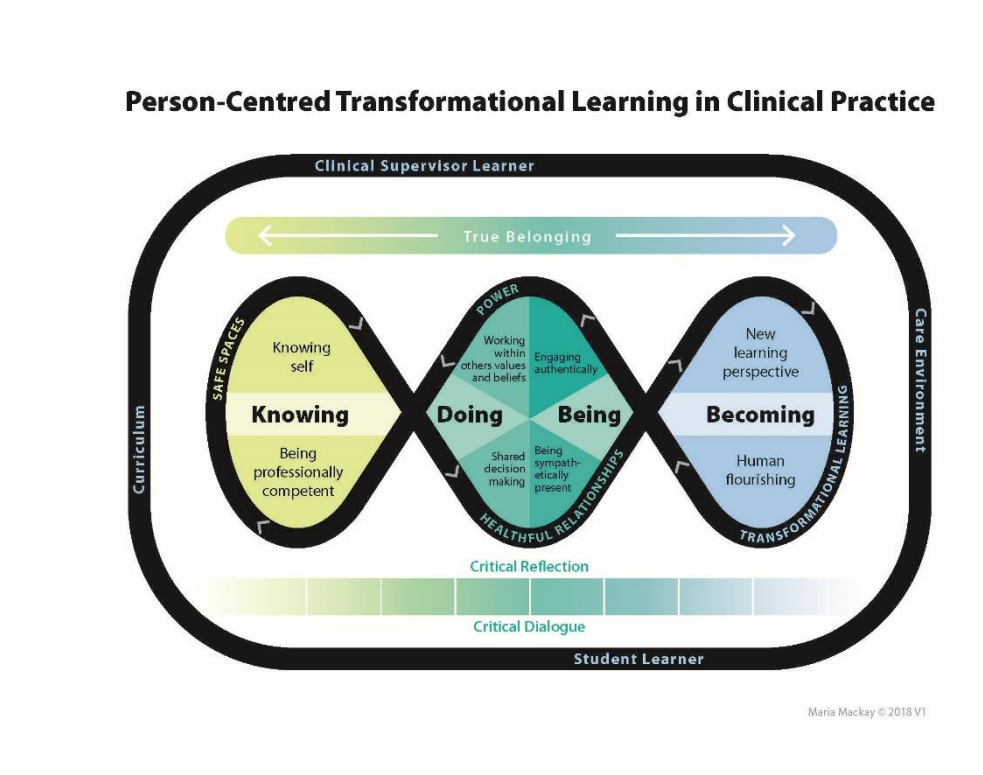


Image 10-15 Person-centred Transformational Learning in Clinical Practice V1 (2017)

I participated in this process as a person-centred researcher and began the process feeling a little anxious because I felt this was a different focus on what we had previously focussed on with the supervisory relationship and connection to emotion

through the use of emoji. I worried that it may be a challenge to bring so much information together. I was pleasantly surprised and felt a sense of wonderment towards the co-researchers, in how open they were to share their learning and to challenge each other further to develop a shared understanding. This process like all others was completed separately by both groups. The student co-researchers only reviewed student transcripts and clinical co-researchers only reviewed clinical supervisor transcripts. My role has been to join both stories and to bring their voices to the surface whilst adding my voice to the story of how healthful relationships influence Person-Centred Transformational Learning in Clinical Practice.

This second set of discoveries is where I continue with synthesis and begin the process of meta-synthesis as I analyse my theoretical framework. The process for meta-synthesis included information from the voice of students and clinical supervisors in the form of their transcripts from the synthesis workshops in part two and the two initial publications (see Appendix B and D) as they both related to the learning that occurred across the classroom and practice settings in the pre-registration Bachelor of Nursing. The process of synthesis as indicated earlier in this chapter was followed:

1. A naïve read where all five groupings of information were read by myself.
2. The next step was a synthesis of information. Firstly, this approach was to consider the similarities and differences between the student and clinical supervisor groups, then I considered the information more globally against the research question. I then checked in with one of the supervisory team and had a critical conversation about what was emerging.
3. The third and most complex step was to create a shared and comprehensive understanding across the student and clinical supervisor groups of healthful relationships and its influence on ‘Person-Centred Transformational Learning in Clinical Practice’ a creative and reflective process. I again checked in with one of the supervisory team and had a critical conversation about what was emerging. I also shared this with the participants and an expert group of academics to enable ongoing critical dialogue and reflection.

Meta-synthesis considered the overall question and required me to contemplate all five groups of information collected and to use my voice to bring a complex array of information together. In the synthesis of information collected in part one of the larger research collection project, co-researcher groups contemplated the combined wordles, the 'Person-Centred Transformational Learning in Clinical Practice' theoretical framework, and the synthesis workshop transcripts from part one. We again utilised the Dadirri poem to enable deep listening and quiet still awareness and allow time for the co-researchers to contemplate the messages they received from their reading (Ungunmerr 1988). As described in Chapter 9, the co-researchers participated in a critical dialogue (Mezirow 1990) with each other and myself. I have considered the transcripts from that along with the publications to bring my voice to each of the concepts of Knowing, Doing, Being and Becoming. I have also added in the initial transcripts to illuminate the meaning derived and revisited the two publications that arose from the exploratory phase of this PhD research. In the process of the naive read of this information, I considered what I felt, heard and sensed in the transcripts from part two using Dadirri (inner deep listening and quiet still awareness) (Ungunmerr 1988). I sat within the ying-yang circle at Kangaroo Valley, Australia, and contemplated with the intention of again being open to hearing the voices of the co-researchers from both groups (see Image 10-16).

Image 10-16 Reflection Using the Ying-Yang Circle in Kangaroo Valley, Australia (2020)

I also revisited my ideas about transformational learning and considered what this meant more broadly for person-centred transformational learning in the practice context. There is much known about transformational learning in a classroom setting, however, little is known about person-centred transformational learning in the non-classroom or clinical practice setting. Transformational learning has been explored in Chapter 6, from the work of Jack Mezirow (2009) and this research has been influenced by his work in the development of the theoretical framework below, specifically in the areas of the use of critical dialogue and critical reflection as transformational learning processes that influence or provide learners with ladders to surface when experiencing disorientating dilemmas and enable the development of new learning perspectives or ways we see and understand knowledge in the reality of practice (Mezirow 2000). My theoretical framework (developed previously in this thesis) brings together several emerging theories to create the image (see Image 10-17) below of Person-centred Transformational Learning in Clinical Practice.

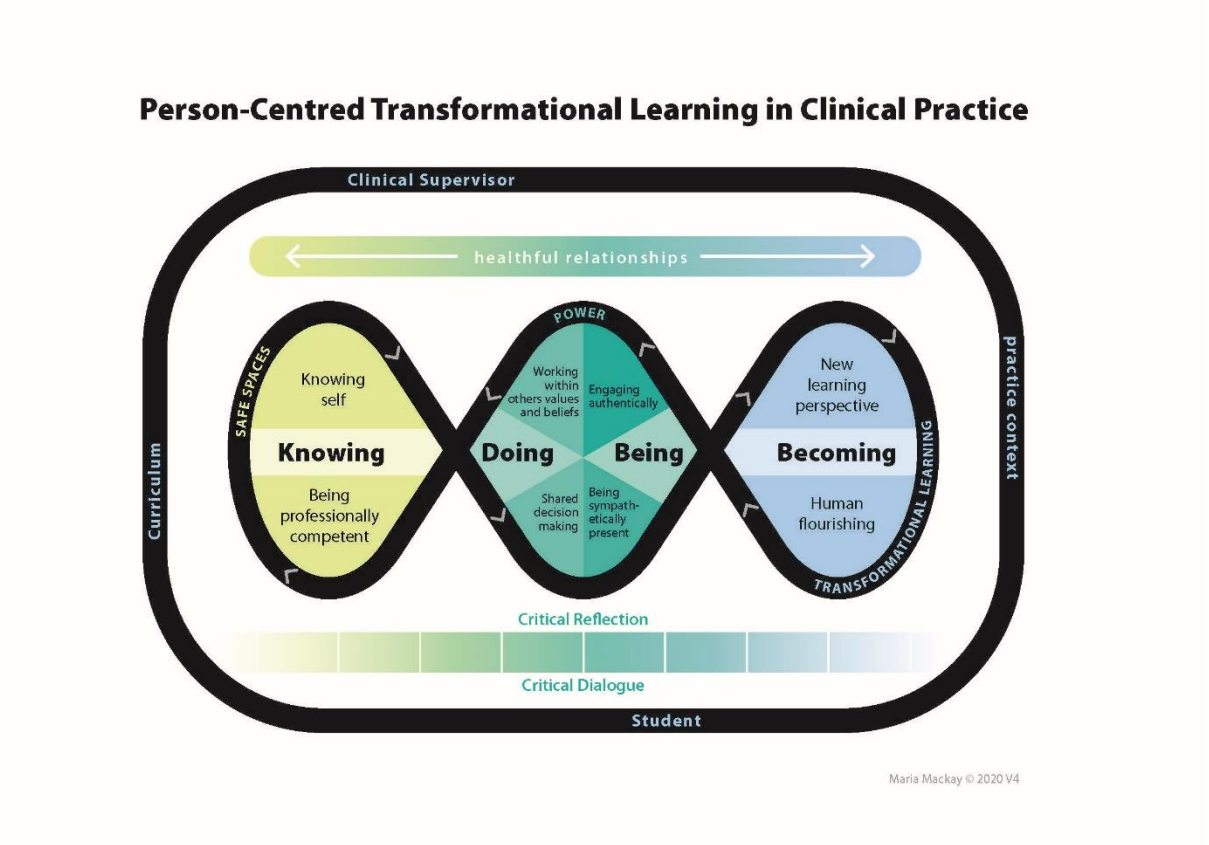


Image 10-17 Person-centred Transformational Learning in Clinical Practice V4 (2020)

The concepts of Knowing, Doing, Being and Becoming have been explored within part two of the information collected for this research with the aim to understand how healthful relationships influence person-centred transformational learning? I believe this research is extending the understanding of transformational learning in the practice context whilst also extending the understanding of transformational learning to more overtly consider person-centredness. I argue that transformation is part of person-centred learning however I feel it is important to have both concepts overtly stated in the heading to ensure they remain at the forefront of approaches to learning in practice. I will now explore the discoveries that became apparent under the headings of Knowing, Doing, Being and Becoming and its relationship to the Person-centred Practice Framework (McCormack and McCance 2017). In the following exploration, I believe I move from a synthesis of what was discovered to a place of meta-synthesis as I am now including the synthesis of this information to include the influences of the theoretical framework above (see Image 10-17).

Knowing

Knowing as a learning process has been related to the McCormack and McCance (2017) Person-centred Practice Framework under the pre-requisites of being professionally competent and knowing self. These pre-requisites have been cooroborated in this PhD research. There was shared recognition that in the Knowing phase of the 'Person-centred Transformational Learning in Clinical Practice' (see Image 10-18 below), there needs to be an equal consideration of the technical skills required and emotional preparation for the reality of practice. From my experience as a DCL over the last ten years, I would argue that currently there is an emphasis on the preparation of both students and clinical supervisors with regard to the technical preparation or the 'how to do' in practice rather than emotional preparation for 'how to be' in practice. Within the meta-synthesis, I have considered all five information groups and how they have impacted on further developing the understanding of relationships between healthful relationship and person-centred transformational learning in the practice context. I have discussed the discoveries as they surfaced for me, with one of the members of my supervisory team, to ensure I continued to engage in critical dialogue throughout the process (Mezirow 1990). The Knowing phase of the theoretical framework in the preparation or classroom/online preparation for a practice experience (see Image 10-18).

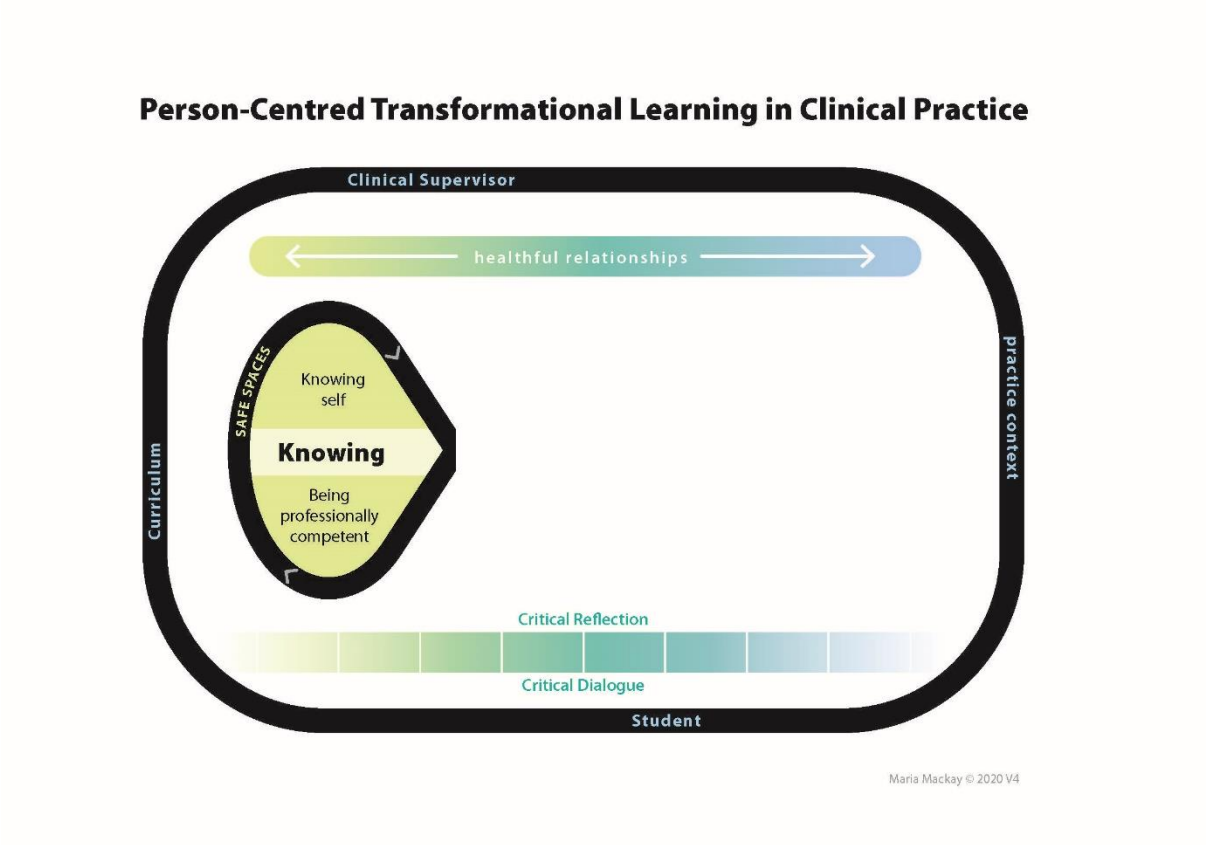


Image 10-18 Knowing Phase Person-centred Transformational Learning in Clinical Practice V4 (2020)

Knowing self was raised in the two publications (see Appendixes A and C) included within the information collection that was reviewed for this meta-synthesis. These publications were generated from projects completed and published as part of the exploratory phase of this PhD research, both revealed information to support knowing self as being important in preparation for practice. The students' voice was evident in the publication – 'Enabling the voice of nursing students in designing an educational resource for their preparation to participate in the reality of clinical practice.' The findings within this publication support the discovery that there is a need for the emotional preparation for practice for students, as it was found that when students use their voice and share their vulnerability through having a conversation about values, expectations and fears, they create more human-to-human relationships with their clinical supervisors. Participants also highlighted that technical preparation is important however, they felt this was expected to occur where the emotional preparation does not have the same emphasis. The second publication was from the clinical supervisor voice titled – 'How do we consider the impact of clinical supervisor

education? A participatory literature review' (Mackay et al. 2019). This publication argues that clinical supervisors require preparation prior to a placement experience to enable them to create shared values and influence the development of person-centred learning cultures. In both, the above publications, being professionally competent to engage in the reality of practice includes the emotional preparation for practice.

Within the part two student synthesis workshop, there was a discussion on knowing self and the impact this has, not only on their experience in practice but also on their life as they were starting to see creating relationships differently. We are in the process of implementing a new curriculum in the university where I work that has included emotional preparation and after experiencing this, Emma (*part two, information synthesis workshop transcript*), a student co-researcher shared the impact related to her placement experience:

> The things that (the subjects) have taught me and prepared me for placement has also given me that ... They've been valuable tools for my life in general. Everything I do now I'm reflecting on in the same way that I'm reflecting on placement, I'm reflecting on things I do in my life. That's something I also got from both of those subjects.

Laura (*part two, information synthesis workshop transcript*), another student co-researcher then shared how better prepared she felt from having considered self in the Knowing phase of her program prior to the placement experience:

> I think it really mentally prepared you, preparing yourself with your values, and learning who you are but also preparing you to deal with other people, and not supervisors, and just understanding those relationships. I think if you had gone onto a placement without having that foundation, it would have been so much more daunting, probably … a lot more difficult. Because you already see how when you're looking at the pictures in those PDFs that people are already facing a lot of, confliction and confusion, and I feel like that would have just been so much more intense had we not had that preparation to teach us what we were going into, and how to deal with things if we were challenged.

The clinical supervisors also shared their feelings of being prepared emotionally as one that enhances both developing relationships and student learning. Emotional preparation has been included within the clinical supervisor educational workshops for some time, however, it was the students within the student-led conversation project in

the exploratory phase of this PhD research, who raised my attention that we were preparing our supervisors well to create relationships, but we were not placing the same focus on students. Percy (*part two, information synthesis workshop transcript*) a clinical supervisor co-researcher related the clinical supervisor preparation to improved learning and feeling satisfied in the role of clinical supervision:

> ... in preparation, we have shared values and we always have to come up with responsibilities, which are shared fostering a partnership, which will result in team-approach encouraging whilst individual growth and development and it's resulting in great student learning outcomes and great clinical supervisor satisfaction as well, in terms of achievement.

Both students and clinical supervisors saw value in face-to-face preparation in the Knowing phase regarding their emotional preparation. The students felt they were prepared with their current online preparation however, face-to-face would allow for more authentic dialogue, Emma (*part two, information synthesis workshop transcript*), a student co-researcher summarised this well by saying:

> I wonder if it's more the way it was presented as well, as a self-learning module. Maybe those ideas are easier to bounce around if you're in a classroom with other people. I know we had the online classroom, but I know the general feeling where I was that I don't know these people, I don't want to talk to them.

The value of face-to-face learning was supported by the clinical supervisors in the publication (Mackay et al. 2019). The findings within this publication supported that clinical supervisors feel more confident and after attending education, they wanted this to be held prior to placement. The face-to-face educational experience enabled them to network and create relationships with their peers. They also advocated for a variety of modalities to support their learning needs.

Being professionally competent was considered important and beneficial to person-centred transformational learning also as part of the shared story. Being professionally competent was included but had less emphasis than the value of emotional preparation. I believe this relates to an expectation that Knowing or educational content would include the technical skills required to perform tasks.

Loreen *(part one, round one interview transcript),* a student participant in her interview, shared that she values preparation in the classroom to enable her to be professionally competent:

> one of the residents with no hypothalamus who constantly needed monitoring, ... she could just slip into, her sodium levels are too low, ... I think having that and knowing like, knowing what's normal and what's not normal really helped my practice as a student.

Marylou *(part two, information synthesis workshop transcript),* a clinical supervisor co-researcher, supports this in her interview, outlining the importance of being prepared to do your role with confidence:

> I'd say that knowing what, is the expectation for the students at that particular clinical placements, having a knowledge of their, … subject is really important. Their scope of practice, and the actual experiences that they've had. I would say that it's obviously important for me to know that these students.

Both the student and clinical supervisor co-researcher groups thought the pre-requisites in the Knowing phase were a good fit. I asked if they would change anything and neither group wanted to change the pre-requisite to this section. The shared story that has emerged is that Knowing in person-centred transformational learning is the preparation that occurs prior to the placement experience and needs to have an emphasis on emotional and technical preparation for placement. In summary, I believe the information collected demonstrated healthful relationships influence person-centred transformational learning in the Knowing phase of their learning in practice by supporting both the student and clinical supervisor to develop an understanding of knowing self as enabling belonging and respecting personhood (McCormack and McCance 2017). Emotionally preparing both student and clinical supervisor with learning resources that are equivalent by challenging them to consider their values and beliefs influence the creation of healthful relationships, which in turn enables a level of awareness in learners about how they respond to situations that challenge them. Marc Brackett (2019) in his book, *Permission to Feel*, argues that we need to have both teachers and students undertake education on understanding their emotions and emotional skill development in school-based learning. I believe this research supports the development of learning and teaching resources that develop emotional skill

development for students and clinical supervisors. The final validation in this research is the need to have equivalence in how both students and clinical supervisors are prepared in the Knowing phase to create a relationship with each other.

Doing

We then moved to the Doing phase of the framework (see Image 10-19 below) and both groups were positive moving through the process, which helped my confidence that the approach was appropriate to discover the influence of healthful relationships on person-centred transformational learning. Doing has been related to the person-centred processes within the Person-centred Practice Framework. The emphasis within the information collected was on the development of mutual respect and trust in this Doing phase. This supported the learners to accept the uniqueness each had to offer. Shared decision making was less obvious however, that does not dismiss its importance.

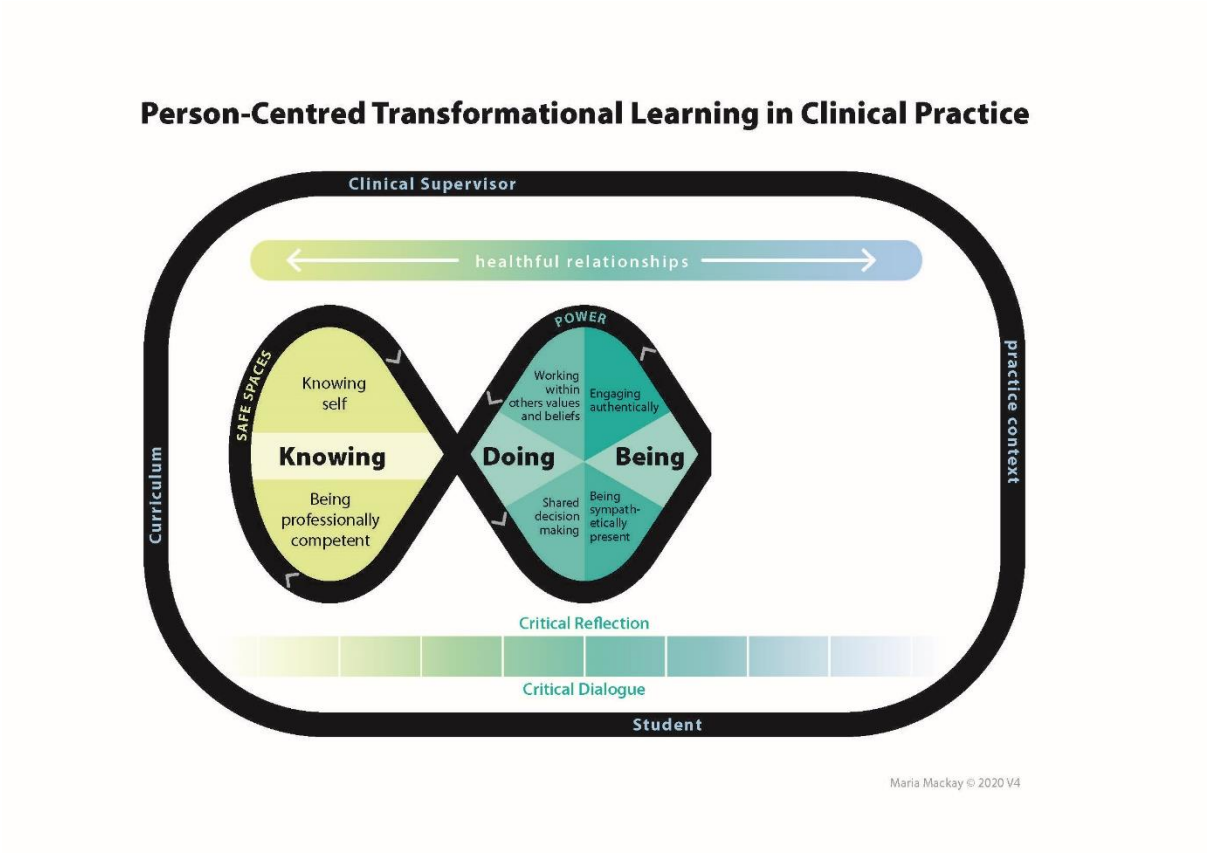


Image 10-19 Doing Phase Person-centred Transformational Learning in Clinical Practice V4 (2020)

Doing in practice is related to the technical side of undertaking the skills of a nurse and clinical supervisor. Doing as skills was evident in the information collection however in addition to the skill, learning was gained from Doing in the form of active learning and understanding self, challenging values and beliefs and belonging.

Alissa, *(part one, round one, interview transcript),* a student participant, describes her learning in practice through Doing and acknowledged that by being enabled to do, she also connected to offering hope and gratitude:

> In the second week when I was allowed to start Doing things hands on, and that was the first day of that change, it just made me feel a bit more content. And so I was grateful to her and that I was now allowed to start having these opportunities.

Belinda *(part two, information synthesis workshop transcript*) another student co-researcher also considers learning as Doing as creating as contributing to being motivated and committed to learning: "Being committed to actually learning, putting into practice what you've learned in class, in labs, into your placement." She expands on this and I felt moved to shared decision making where she has a role and voice on leading as a student by example and supporting her peers to consider how they create relationships in practice with their supervisor:

> I think also, even though you are a student, I think you should still be leading by example, like treating people the way you also want to be treated. Supporting your other students and being supportive of your supervisor or your preceptor, showing that mutual respect and building those helpful relationships.

Clinical supervisor co-researchers reflected on the challenge of giving feedback after creating positive relationships with students. Giving feedback is an essential skill for clinical supervisors, it was felt that this was challenging for the clinical supervisors as they were mindful of maintaining the established relationship, Kathy *(part two, information synthesis workshop transcript)* a clinical supervisor co-researcher believes the use of language is important:

> I'd like to say about getting feedback, ...when you already have this relationship with the student and saying the right words. So, that relationship, even if you're going to give negative feedback to them, you don't want to break that relationship that they've already built up with you because you don't want that affect it, it affects next clinical days, you … you want that feedback to be part of them to become better, not to go backward. It's about. It's about choosing the right words in giving critical feedback.

Again, in the Doing phase, student and clinical supervisor co-researcher could see congruence with the person-centred processes within this phase and when asked if they would change anything, they stated they would keep this phase as it is. The focus of the conversation with students and clinical supervisors recognised that Doing was an important part of nursing. I found it interesting that they recognised the learning from Doing was not only realised in undertaking psychomotor skills for students or Doing the role of supervision and assessment for clinical supervisors but also in the critical reflection and critical dialogue that forms part of the process (Mezirow 1990). It is when students and clinical supervisors are prepared to connect with their emotions that they are able to build on healthful relationships to recognise sparks of healthful learning. Each spark is a healthful learning moment where learners realise they have gained some additional knowledge, understanding, or insight. The complexity of the practice context creates a disorientating dilemma for both students and clinical supervisors, the discomfort of the dilemma creates the initial connection to emotions and feelings. This is then explored further within the healthful relationship through critical reflection and critical dialogue (Mezirow 1990). It is by contemplating the sparks of healthful learning where learners connect the sparks that healthful learning moves towards person-centred transformational learning and the creation of new learning perspectives (Mezirow 1990). A discovery has been the realisation that healthful relationships encourage learners to be open to learn, unlearn and relearn, this is the foundation where person-centred transformational learning begins to seed in the Doing phase of learning in practice. I now move on to the meta-synthesis in the being phase.

Being

The being phase within Person-centred Transformational Learning in Clinical Practice (see Image 10-20 below) also has two person-centred processes embedded within it;

they are engaging authentically and being sympathetically present (McCormack and McCance 2017). These processes were explored by both groups and this section was one where the terms were challenged by the co-researchers. In the process of discovery, I have found that being sympathetically present did not sit well with the clinical supervisor co-researcher group. Both groups preferred the term empathy, however after reading the definition provided for being sympathetically present the student co-researcher group accepted the term, whereas the clinical supervisor co-researcher group would prefer the term, being empathically present. We then explored this in detail with the clinical supervisor group and realised it was the difference between sympathy and being sympathetically present they were challenged with. Being sympathetically present is defined by McCormack and McCance (2017, p. 57) as "an engagement that recognises the uniqueness and value of the individual, by appropriately responding to cues that maximise coping resources, through the recognition of important agendas in their life." Landers and McCarthy (2015, p. 80, 81) support the definition of sympathetic presence utilised within the Person-centred Practice Framework and state: *"The concept of sympathetic presence emphasizes the importance of engaging with the person. The nurse demonstrates regard for the uniqueness of the person and values contributions to the decision-making process."*

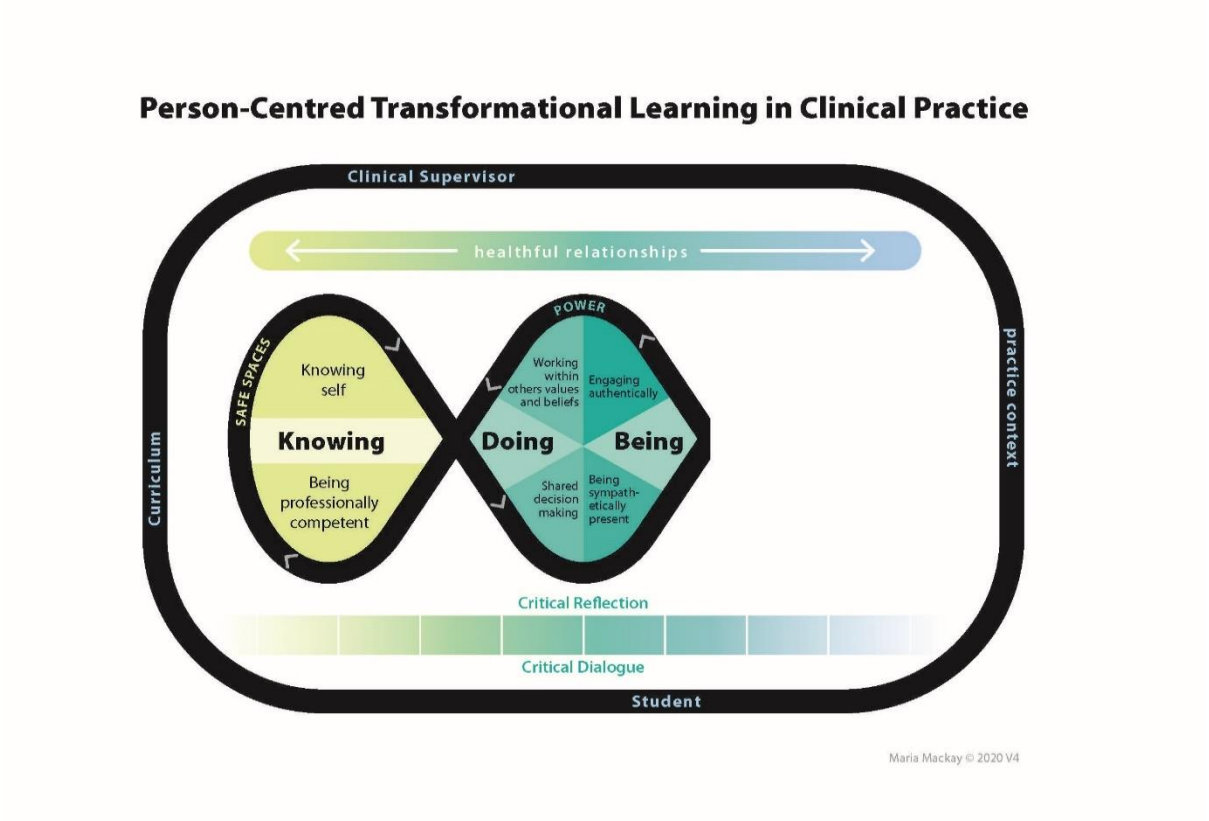


Image 10-20 Being Phase Person-centred Transformational Learning in Clinical Practice V4 (2020)

The clinical supervisor co-researchers in their part two synthesis workshop felt sympathetic presence was a key element of being with students to companion them to consider self and be reflective within their own practice.

Brenda *(part two, information synthesis workshop transcript)* as a clinical supervisor co-researcher believes that being sympathetically present with the student in challenging conversations helps them to work through their discomfort and sparks new learning; they are considering the impact of holding space: “I think how to handle difficult conversations or how to handle a patient, a student that isn't going the way that you want them to go, when they do something wrong, how to handle those issues.”

We then read the meaning outlined of being sympathetically present. The definition was accepted by the clinical supervisors. We needed to sit in the discomfort and consider what being sympathetically present meant for person-centred transformational learning. I believe that concerns by the co-researchers in this PhD

research represent a confusion that exists more broadly of sympathy versus being sympathetically present and raising further awareness of the differences is positive for the application of the Person-centred Practice Framework (McCormack and McCance 2017) in terms of crafting healthful relationships. The critique of the term sympathy versus being sympathetically present will be further explored within The End of the PhD Journey – Discussion, Chapter 12.

The student co-researchers reflected on the transcripts and realised learning for them was that student participants talked about learning from the registered nurse you want to be and also from the ones who you do not want to be. This was described in an observational way where they indicated that they are heightened to recognise the registered nurse they want to be and don't want to be as a result of demonstrated behaviours. They identified that they challenge themselves to behave in a way that is consistent with the registered nurse they want to be. Student co-researchers were also aware that being in practice and with others is the difference between the science and art of nursing (Watson 1999).

Belinda *(part two, information synthesis workshop transcript),* a student co-researcher expressed this in the part two synthesis workshop by stating being as: "… it's kind of the difference between the science and the art of nursing, isn't it? You're Doing the science, you're being the art."

Laura *(part two, information synthesis workshop transcript)* another student co-researcher described being as engaging authentically as a commitment to being in practice and how this impacts upon your openness to learn in and from practice:" You could go through the motions of doing what you need to do on the floor, but you might not be committed to it. … not being present."

Sally-Anne *(part one, round two interview transcript),* a student participant considered she felt her clinical supervisor was engaging authentically with her when they challenged using gentle language (Hardiman and Dewing 2019). She described how her clinical supervisor engages with her authentically and helps her to see for herself

that she is not completing her goals. Through authentic engagement she was able to realise that she needed to step up and complete the task:

> This time I think we sat down and just discussed what could challenge me more, from her response because I was saying that I felt okay about everything. My clinical supervisor wanted to know, what do I need her to tell me to make me feel challenged? That was the discussion we had, and I just wrote down, I need to work on my other goals. My clinical supervisor. was very gentle about it, so I hadn't fully filled out all my goals on day three. I think we had two as well. So, yeah, she was quite supportive and helped me to realise, but in a very gentle way.

Temika *(part one, round two interview transcript),* another student participant considered being reassuring and safe made her feel that her clinical supervisor was engaging authentically within their relationship:

> My clinical supervisor spent a lot of time with me, and the other girls. And she really just made herself known that she was always close by, no matter what the problem was. If registered nurses didn't have time to spend with us, then she absolutely would. And it was really nice. She just was very reassuring the whole day. So, like I said, I noted that I felt reassured and safe.

The clinical supervisor's perspective in engaging authentically introduces that concept of holding space for others or companioning them on their journey for discovery.

Pat *(part one, round two, information synthesis workshop transcript),* a clinical supervisor co-researcher relates this to true belonging and enabling personhood; their role is not to change who a person is, rather helping them to walk their own journey. She supports in this to enable personhood in others and not try and accept difference:

> I think that's really interesting because the idea of holding space is to me, I don't even know how to explain what I'm trying to think, but it's walking with someone. It's allowing someone to be who they are. Which is a lovely, lovely idea but I personally don't think that we do that particularly well in nursing as a whole, we expect people to fit in a box. ... but encourage someone to go from being an introvert, to not being an introvert. That sort of thing kind of goes against the whole idea of allowing someone to walk their own journey and us, encouraging, accepting and walk that with them.

Kathy *(part one, round one, information synthesis workshop transcript)*, another clinical supervisor co-researcher further explores holding space or companioning students and the impact this has on students being enabled to seek their full potential:

> Holding space for another person is incredibly profound. When you hold space for someone, you bring your entire presence to them. You walk along with them without judgment, sharing their journey to an unknown destination, yet you're completely willing to end up wherever they need to go ... Yet you're completely willing to end up wherever they need to be, because that means you're giving into the way you feel.

In the Doing phase, the focus is on understanding how we react and respond to others; therefore, we learn more about ourselves. In the being phase of person-centred transformational learning, the focus moves to a place of examining relationships with others, the learner is able to consider their impact on others whilst still maintaining self-awareness of their own growth. When considering being in practice, active listening and companioning enabled the learner to move to a point of insight and contemplation that enabled them to move forward meaningfully (Ungunmerr 1988). A healthful relationship contributes to learning in the being phase by supporting learners to connect with their emotions and giving each of them permission to feel the emotion and consider their reactions and responses (Brackett 2019). I discovered that the participants within this PhD research recognised that by using emoji, this was the conduit for them to connect with the emotions they were experiencing in a relationship with another and enabled them to listen to their feelings and consider how their reactions to these sat with their espoused values.

Kathy *(part one, round two, interview transcript)*, a clinical supervisor participant described the relationship with emoji as helping to connect with other clinical supervisors and students as follows:

> I think I did more interaction than I would have normally, to try and find emoji to, because it made us think, and it stimulated conversation between the facilitators at coffee time, too. That was interesting. It was like, "Do you have a positive? Do you have a negative or a challenging emoji? What's it for and what's it around? That was part of our debrief as facilitators on placement. ... I think it makes you think a little bit more about your students and the relationship that you have between your students.

My final discovery was that the art of active listening and companioning forms the foundation for students and clinical supervisors to connect the sparks of healthful learning and to ignite these moments to form connections. It is the connections that are made where person-centred transformational learning is gained. The connection to emotions brings awareness to learners' inner or embodied knowing.

Becoming

The final aspect of person-centred transformational learning we unpacked as part of the co-researcher workshops in part two of the PhD research was the Becoming phase (see Image 10-21 below). The critical dialogue and exploration of person-centred transformational learning followed the layout of the model, however, in reality this is not a linear process (Mezirow 1990). New learning perspectives and human flourishing may be evident to learners at any point in the Knowing, Doing, and Being phases of person-centred transformational learning. I have described Becoming in the context of person-centred transformational learning has been described as the creation of a new learning perspective (Mezirow 2000) and human flourishing (McCormack and McCance 2017).

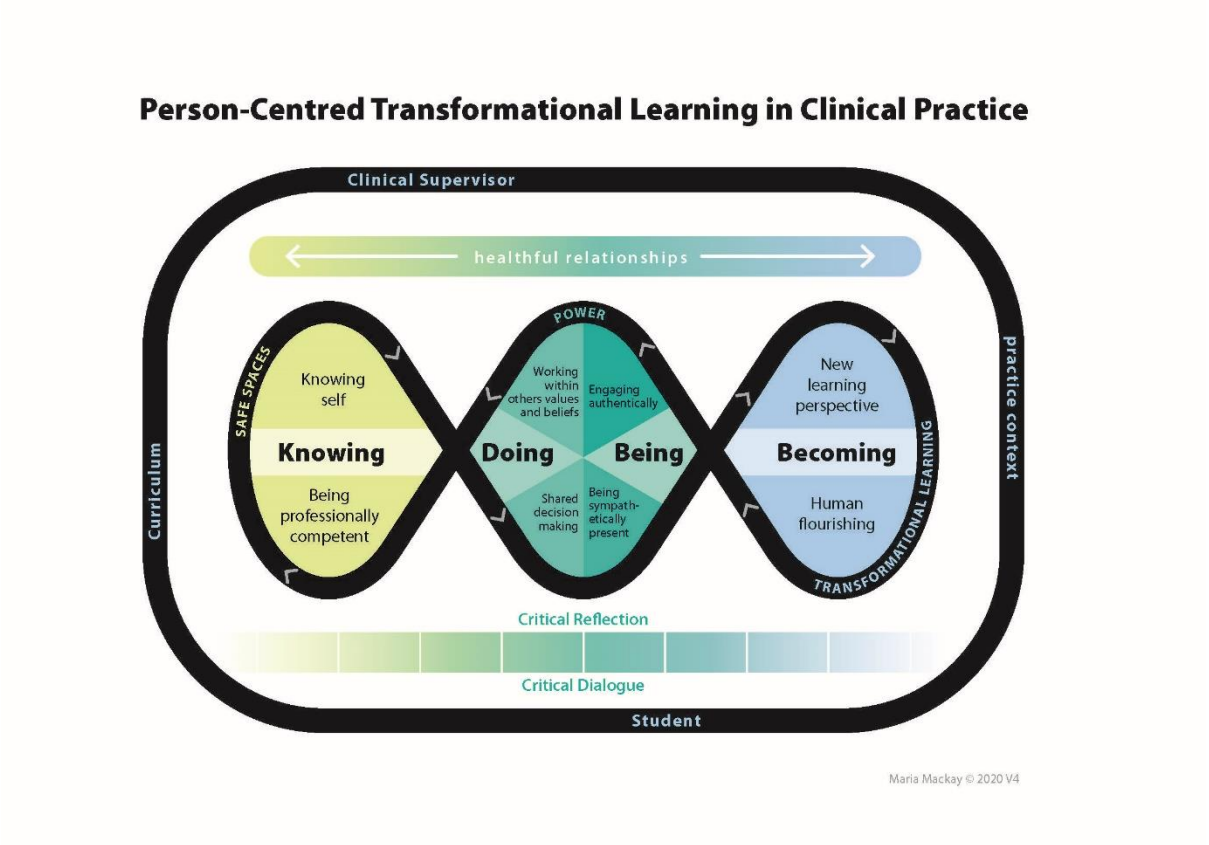


Image 10-21 Becoming Phase Person-centred Transformational Learning in Clinical Practice V4 (2020)

At the completion of each of the synthesis workshops in phase one of the PhD research, each group (student and clinical supervisor) completed a Haiku (Iida 2010) to summarise their learning from participating in the research. The following are the two verses together for each of the groups.

Firstly, the students have considered the phases of Knowing through challenging self, being through their impact on others, and how this leads to Becoming with growth between all of us. I believe the Haiku below demonstrates great insight from the student group and also demonstrates the value of the student's voice in research regarding their learning and teaching strategies and tools. The student co-researchers *(part one, round one and two information synthesis workshop transcripts)* contributed to these verses:

Challenging myself
through the impacts of others
I must remain strong

Anticipation
Positive and stained for some
Growth between all of us

Secondly, the clinical supervisor group in their Haiku demonstrates their sense of flourishing from the passion they hold for the role of clinical supervision and the benefits of gaining new learning perspectives from sitting with the discomfort of a disorientating dilemma. This relates to the use of critical reflection and critical dialogue for both themselves and the students to grow from the challenge. The clinical supervisor co-researchers *(part one, round one and two information synthesis workshop transcripts)* contributed to these verses:

We love what we do
Students are worth the challenge
Facilitation

Facilitation
Challenging and Rewarding
Communication

Student co-researchers in the part two synthesis workshop explored the concept of Becoming as a new learning perspective surfacing from being challenged.

Laura *(part two information synthesis workshop transcript)* a student co-researcher referred to challenge as: “Perhaps having challenges, that's pretty transformative. And from challenge comes benefit.”

Laura then extended this to consider the sparks of healthful learning from connecting with emotions, challenges and discomfort and how this brings about self-awareness and a sense of authenticity. The movement from sparks of healthful learning to a place of flourishing may occur in what feels like a battleground, however, in reality, this is the turbulence of the practice context, she *(part two information synthesis workshop transcript)* as a student co-researcher stated:

> I can recall times where it does feel like a battle and it's awful. But if you can, take from these experiences, that sense of self-control, or at least, the very first step is, feeling emotion and catching it. No matter what happens if it still runs wild, that's fine, but if you can catch it and acknowledge it, that's when you can start rolling it and letting you be more authentic.

Student co-researchers realised that connecting sparks of healthful learning are what helps them to ignite their learning and by bringing the sparks together, they, therefore, create new learning perspectives. They feel that connection to their emotions in the context of their relationship with their clinical supervisors helps to make this connection and brings about a feeling of flourishing.

Clinical supervisors recognised they have a role to create an environment for learning. One that enables the students to produce new learning perspectives; they were less aware of this role in their own learning.

Ashley *(part one, round two, interview transcript),* a clinical supervisor participant, when describing a conversation with a student stated:

> Let's go and have a look. Let's look at these steps. Is this what you saw when you witnessed ... whatever the thing was that happened that the policy was. And then you can discuss steps missed, and that kind of thing. You see it in their faces, those light bulb moments where it kind of all starts to make a little bit of sense. And that motivates them to be quite engaged because it makes sense.

Genoveva *(part one, round two, interview transcript),* another clinical supervisor participant considered flourishing occurred when the learner felt safe, she stated:

> I felt it's not only the student feeling safe, they were on the right track and passing their assessment. Yeah. I think it's the clinical supervisor or at least this is how I feel. I feel, yes. I feel safe. I feel things are going right.

Ngaire *(part two, information synthesis workshop transcript),* a clinical supervisor co-researcher brought the sense of Becoming together when she said:

> I really like when a *wow moment* comes out of them and they no longer see you as an older person/nurse and I no longer see them as a young person/student, we are just two nurses in practice together.

I felt this immensely powerful statement showed how healthful relationships in practice enable both students and clinical supervisors to help each other to seek their full potential.

On challenging both the students and clinical supervisors if they would change the concepts of new learning perspectives and transformational learning, neither wanted to change them. I discovered the overall concept of Becoming is one where new learning perspectives are realised and transformation in how the learner understands the world is experienced. The preparation in the Knowing phase of transformational learning has a role in the emotional skills the learner brings to the phase of Becoming. Through Doing and Being in practice they are then able to use critical dialogue and critical reflection to learn about themselves and others and have the capacity in the being phase, to actively listen and to companion others in their learning journeys (Mezirow 2009). Healthful relationships influence the learner to be emotionally prepared to connect their mind and heart and be open to experiences within the practice context. Becoming as a concept may occur during a placement experience. It also may occur at other times as continual reflection and critical dialogue occurs in the reality of our everyday lives; students engaging in their classroom-based learning and teaching and clinical supervisors interacting with each other and participating in their education workshops on a bi-annual basis (Mezirow 1990).

The Overall Influence of Healthful Relationships on Person-centred Transformational Learning

Overall, I believe from the information collected and the synthesis undertaken by the participants and co-researchers in this PhD research, we have collectively demonstrated that healthful relationships are integral to enabling person-centred transformational learning in the context of practice. Healthful relationships between students and clinical supervisors enable learners to move through Knowing, Doing, Being and Becoming, supporting them to maintain a clear focus on themselves whilst simultaneously engaging with others to facilitate shared learning. Person-centred transformational learning is not an isolated spark of healthful learning, rather it is a way of being open to learn, unlearn and re-learn from Knowing, Doing, Being and

Becoming in the context of practice. I feel the development of healthful relationships is the conduit for new learning perspectives and flourishing to emerge from within the students and clinical supervisors.

This research's learnings have resulted in the Person-centred Transformational Learning in Clinical Practice being revised with minor amendments. The revised theoretical framework is below (see Image 10-22 below).

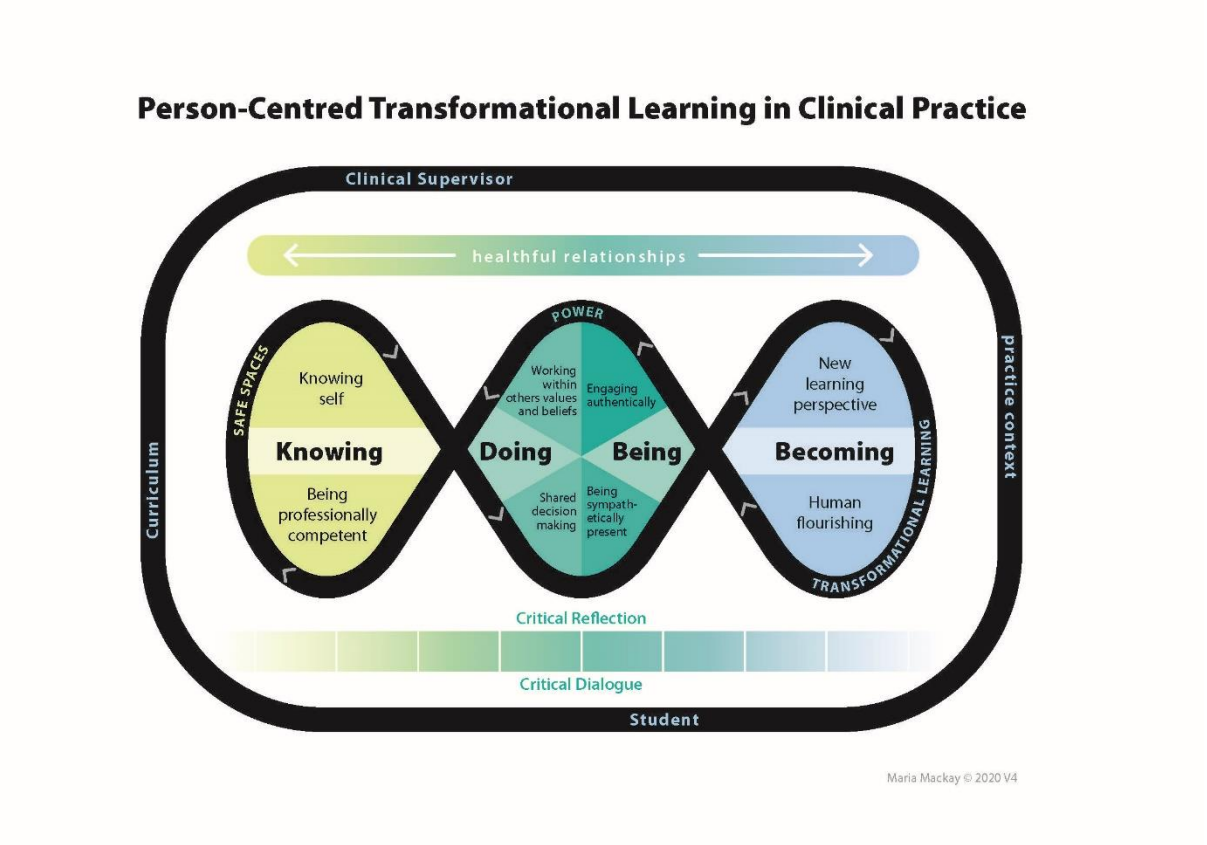


Image 10-22 Revised Person-centred Transformational Learning in Clinical Practice V4 (2020)

The first change was made to the initial banner at the top of the model, which was initially true-belonging and has now been morphed as a result of the research to be healthful relationships. Healthful relationships moved from the infinity circle as described in previous versions of the model to be recognised as being fundamental concepts across all of the phases of Knowing, Doing, Being and Becoming and is a core component of person-centred transformational learning in practice. As discoveries revealed from this PhD research, knowing self to enable belonging is embedded as essential to healthful relationships along with respecting personhood.

Moving healthful relationships to the banner at the top of the model acknowledges the influence of healthful relationships as a holistic concept that influences all aspects of person-centred transformational learning. The other changes were grammatical changes where the words for student clinical supervisors have had the term learner removed as all persons engaged in the relationship were learners inherent within person-centred transformational learning. The clinical environment was changed to practice context as this is a more holistic and encompassing term.

Chapter Summary

In this chapter, I have found my voice in sharing the collective story and understanding that has emerged from the synthesis and meta-synthesis of information across the entirety of this PhD research. I have added my voice to this by bringing together all groups of information which has allowed me to now be present in the two sets of discoveries. I hope that by continuing to be mindful of the need to bring each of these individual groups' voice to the forefront of the discoveries that have come to the surface and from the participant and co-researcher validation, I feel confident their voices are present. This chapter has provided a synthesis of the findings and created an understanding of what is required to create healthful relationships between students and clinical supervisors in the practice context. I have also demonstrated that emoji are a tool that is useful to help persons connect to and reflect on their emotions. Dadirri has again been dominant in the process of contemplation enabling synthesis to be undertaken and providing space to contemplate the information collected through the entire PhD research and for the discoveries to be heard (Ungunmerr- 1988). Finally, I believe the chapter has created an understanding of how healthful relationships influence person-centred transformational learning in the practice context and how this provides the opportunity for both students and clinical supervisors to create new learning perspectives and feel a sense of human flourishing.

Using inner deep listening and quiet still awareness, I listened to the voices of the participants and co-researchers and have developed a shared story that discovered the following seven synthesised themes.

These themes are underpinned by the theoretical and methodological frameworks:

Theme 1 - Students across all years should have a voice in developing the learning and teaching resources within curricula.

Theme 2 - Education to prepare students and clinical supervisors should be offered in a variety of modalities and have an emphasis on both the technical and emotional preparation for the reality of practice.

Theme 3 – The creation of person-centred transformational learning cultures should be underpinned by the development of healthful relationships that are based on knowing self to enable belonging and respecting personhood.

Theme 4 - The use of emoji as a tool for reflection on healthful relationships enables learners to recognise and respond to their emotions.

Theme 5 – Person-centred transformational learning is generated from the sparks of healthful learning coming together to ignite new learning perspectives and a sense of human flourishing.

Theme 6 – Inner deep listening and quiet still awareness is a powerful reflective process that enables the learner to connect with their embodied knowing.

This chapter completed the synthesis of information, further meta-synthesis is undertaken in Chapter 12, where the key findings are described and critiqued. The following, Chapter 11, moves along the road to reflexivity and rigour and I have demonstrated the reflexive nature of being a person-centred researcher. In Chapter 11, I sat with discomfort and shown vulnerability in the reflexive sharing of my thoughts, feeling and learnings across this PhD research.

This poem summarises my feelings and experiences within the process of synthesis and meta-synthesis.

Poem

Information, Information, Information
Where to start and what to do?
Moving towards makes the task bigger
Moving away helps to maintain a safe distance

Analysis, synthesis and meta-synthesis
They are all separate and entwined
They are all confusing and helpful
They are all a mystery that is Becoming clearer
They all add to the shared story

Dadirri
Inner Deep Listening and Quiet Still Awareness
Learning from silence
Learning from others
Learning to move towards the discomfort.

Vulnerability to expose the discoveries
Are they enough?
Are they right?
Really, what is a discovery?
The discoveries are now part of what I know
They are how I now see the world

Updating the models
Updating the guidelines
Updating learning and teaching resources
Maybe we have discovered enough

Chapter 11

Taking Breaks Throughout the Journey for Rigour and Reflexivity

Image 11-1 Taking Breaks for Rigour and Reflexivity - © Maria Mackay 2020

Introduction

In this chapter I aim to outline the approach to rigour I have taken in this PhD research and define reflexivity as a process for holding myself accountable as a person-centred researcher. The image above (see Image 11-1) represents the part of the road where reflexivity has become significant as in this chapter, however rigour and reflexivity has been included throughout the research process. The concepts of rigour and reflexivity are interlinked within person-centred research to ensure authenticity and transparency in the research process (Probst 2015; Daniel 2018). I start this chapter defining the TACT framework for rigour and place an emphasis on its relationship to reflexivity. Next, I undertake to share how I understand the definition and application of reflexivity and provide specific examples drawn from my PhD research. I have argued that reflexivity as a concept is referred to a lot in nursing research however not well understood in its application (Probst 2015). As I move along in this chapter, I have defined reflexivity and provided a process for its application which I elaborate

by sharing the breaks I took to practice reflexivity bringing together my ontology, epistemology and methodology. The process of reflexivity challenged me to consider and reflect on the methodological principles developed (see Chapter 7) and consider how my participation, assumptions, and biases may have influenced the information collection and synthesis within this research.

Ensuring Research Rigour

Rigour in qualitative research is controversial with no agreement or universal framework accepted for its use (Daniel 2018; Ghafouri and Ofoghi 2016; Polit and Beck 2017). Daniel (2018, p. 263) does describe three stances for rigour that have to be considered if rigour is relevant to qualitative research. Firstly, qualitative research should use an equitable standard as quantitative research to assess validity and rigour. Secondly, there should be different criteria for qualitative research based on the interpretive ontologies. Third, he questions the appropriateness of rigour in assessing qualitative research. Polit and Beck (2017) argue that most qualitative researchers agree there is a need to assess rigour, however, they do not agree on the framework to do this by. Lincoln and Guba (1985) as argued by Ghafouri and Ofoghi (2016) are touted as the gold standard for trustworthiness as an approach to rigour in qualitative research. I have taken an approach to rigour that is primarily underpinned by reflexivity, as this is consistent with person-centred research to ensure high quality research whilst allowing for the conducting of research in a person-centred way (van Dulmen et al. 2017).

Within this PhD research, I have accepted that the concept of rigour should be explored in a way that fits with person-centred research undertaken. I believe the work of Daniels' (2018) TACT Framework meets this as it has a basis in reflexivity, a strength consistent with my work. The TACT Framework was developed in a higher education setting to assist novice researchers with the significance of rigour in qualitative research. The acronym TACT addresses the following concepts: Trustworthiness, Auditability, Credibility and Transferability in determining rigour, for qualitative research and each of these as individual concepts will be explored later in this part of the chapter. I chose this Framework as it was clear, concise and summarised for me

the key ideas of rigour in qualitative research. Furthermore, it is unpinned with reflexivity and therefore enables transparency, reciprocity and critical self-reflection (Probst 2015). Probst (2015, p.42) found in her qualitative study that the benefits of reflexivity include "accountability, trustworthiness, richness, clarity, ethics and personal growth." Further, she argues that reflexivity as a form of rigour contributes to "the integrity of the research process, the quality of knowledge generated, the ethical treatment of those being studied and the researchers own wellbeing and personal growth." These two quotes I believe bring together the relationship between rigour and reflexivity and support the choice of the TACT framework being used within this research.

Trustworthiness requires a systematic approach to information synthesis and is defined as enhancing "the understanding and interpretation of research findings" and "requires the researcher to demonstrate that findings are situated within the views generated by participants" (Daniel 2018, p. 265). The research needs to demonstrate integrity in the process and outcome and be clear about how the conclusions were derived (Daniel 2018). The exploration of assumptions and sharing these with the participants and co-researchers along with a reflexive approach to the ideas, exposed my biases and enabled me to share these with the participants and co-researchers along the journey we have taken together. These ideas will be explored later in this chapter within the process of reflexivity. Trustworthiness has been demonstrated within this PhD research as the systematic approach to information collection synthesis. All interviews and workshops followed an agreed script. Rigour was maintained using triangulation or cross-checking of the steps with my supervisory team and ensuring that both the co-researchers and myself engaged in critical dialogue regarding both the process and the assumptions we held (Mezirow 1990).

Auditability is focused on documentation and description of the process undertaken so that a reader can understand how the research was undertaken and what they can learn from this when they undertake the same process (Daniel 2018). For this research, it included field notes, transcriptions and creative works. These have been shared throughout the PhD journey, largely within The Cobbled Road to Information

Collection and Synthesis with Co-Researchers, Chapter 10 and Discoveries in Meta Synthesis, Chapter 11. Ghafouri and Ofoghi (2016) consider this an audit trail that others can follow, and this increased trustworthiness. The complexity of the information within the five groups that were synthesised at each step individually and finally within the synthesis required audibility to be utmost and ensured I have a clearly documented trail along my journey that others could follow.

Credibility is based on findings from the research being seen as "credible, relevant and congruent" (Daniel 2018, p. 266). This was achieved through a detailed description of the synthesis process and the authentication of the information and knowledge developed. Consistent with the description of credibility by Ghafouri and Ofoghi (2016, p. 1916), validating discoveries with the persons involved within the research, external checking and "triangulation are all forms that demonstrate credibility in the synthesis and synthesis of information." For this PhD research, member checking included the participants and co-researcher checking information collected with findings and investigator triangulation used by more than one researcher being involved in collecting, and synthesising information (Daniel 2018; Ghafouri and Ofoghi (2016). In addition to this the credibility of the discoveries made within this thesis, I have also been member checking with my supervisory team where they have challenged me to ensure I have considered trustworthiness and auditability at each step.

Transferability occurs when the findings of a study can provide learning opportunities to others in similar settings or situations. This is different to generalisability as it accepts the concept of multiple realities (Daniel 2018). Ghafouri and Ofoghi (2016) relate transferability to fittingness and those findings will be the same in a comparable situation. This PhD research fits within the critical paradigm and the acceptance of multiple realities forms part of the ontological assumptions that are described within Discovering Me and My Ontological Values, Chapter 3. I have discoveries within this thesis that may be of benefit to other realities as the development, implementation and evaluation of person-centred learning and teaching resources have similarities in other pre-registration nursing programs. There is potential that the discoveries may have

some applicability to other professional degrees for health-related professionals who are interested in developing person-centred transformational learning opportunities in the practice context.

My Interpretation of Reflexivity

As a person-centred researcher, I have used creativity, reflection and reflexivity as a way of Being and Becoming a person-centred researcher (McCormack et al. 2017). I hold the assumption as previously inferred in Chapter 10, that there is a relationship between the state of Being and the flourishing that occurs with 'Becoming'. This assumption provided the impetus to explore how to embed reflexivity into my being as a researcher. I was unsure of where to start and what reflexivity meant and although I should not have been surprised, I found that my overall understanding and definition of reflexivity was not clear. Further, in this review of the literature on reflexivity, I could not find an explanation of how to practice the art of reflexivity. This is supported by Probst (2015) where she purports that current evidence defines reflexivity however does not provide any guidance on how to undertake the practice of reflexivity. Consistent with my approach to understanding and creating meaning for concepts within this PhD thesis, I, therefore, created my own representation below (see Image 11-2). In this reflexivity representation, I aimed to describe how I understand reflexivity and the process of reflexivity in Becoming a person-centred researcher from the perspective of a PhD student. This process helped me to gain a deeper and more meaningful understanding of how to embed reflexivity into my practice.

Defining reflectivity was my first step in beginning to understand the concept that I had heard spoken so frequently, but in reality, did not fully understand. Finlay (2002) in a paper titled 'Outing the Researcher', considers reflexivity to be thoughtful, conscious self-awareness. I resonated with the concept of outing myself as a researcher as I hoped this would help me work through the discomfort of person-centred research. She described this as a process where the researcher moves "back and forth in a kind of dialectic between experience and awareness" (Finlay 2002, p. 533). A simple and easily understood definition that Finlay (2002) had considered when constructing her definition of reflexivity was that it is "… an ongoing conversation about the experience

while simultaneously living in the moment" (Hertz 1997, p. viii). The definition of reflexivity within the Person-Centred Healthcare Research book (McCormack et al. 2017, p. 35) is from Malterud (2001) where "reflexivity is defined as an attitude of the researcher, attending systematically to the context of knowledge co-construction, especially in relation to the effect on the researcher, at every step of the research process." The above definitions highlight the importance of self-reflection and awareness of assumptions as part of reflexivity. Importantly, the person-centred definition considers the researchers' worldview and assumptions should be understood and shared as part of the research process. I, therefore, now hold the view that reflexivity is a dynamic process where I challenge assumptions that have surfaced as I explored the underpinning ontological, epistemological and methodological principles of this PhD research.

The next step for me when considering reflexivity was to contemplate how I would demonstrate reflexivity in my development as a person-centred researcher. Mezirow's (2000) model of reflection uses the concepts of unpacking one's assumptions to reflect on a disorienting dilemma to transform our learning perspectives or the way we see and understand the world. I have explored and explained Mezirow's (2000) model of reflection in the Taking the Road to Developing a Theoretical Framework, Chapter 6, and utilised the reflective concept of unpacking assumptions in the Discovering Me and My Ontological Values, Chapter 3. Finlay (2002) argues that reflexivity is undertaken differently within individual research paradigms and should include as a minimum requirement the identification and acknowledgement of research bias. Bias from the perspective of rigour fits within transferability in the TACT Framework (Daniel 2017). Exploring and understanding assumptions enabled biases to surface and be acknowledged. I, therefore, felt the process for reflexivity for me included a more iterative and deeper reflective process of identifying and unpacking some of my deeply held assumptions that had surfaced in the previous chapters.

To clarify how I purposefully taken breaks in this research to be reflexive and thus ensure rigour and congruency in my research, I have developed a model for reflexivity as portrayed below in image (see Image 11-2). I have used the concepts of inner space,

outer space, the universe to achieve reflexivity through the authentic use of self as a researcher. I used these concepts as I felt they helped me to describe a model that is easily understood and enabled me to consider myself and my assumptions whilst being mindful of my influence on others involved within this research. The process of reflexivity I have described begins with an understanding of my inner space or who I am as a person-centred researcher, and then moving to the potential impact my inner space has on the size and influence of my outer space, particularly how this is portrayed in my voice and actions as a researcher. Next, within the universe, I take time to explore what I am seeking from the universe consciously or unconsciously from my outer space and how this influences what I am seeking to see and learn from being part of the research process. Finally, in reflexivity, I needed to take time, contemplate and reveal any new learning or gems I may discover and consider them with honesty and authenticity as part of the research process. I found this process helped me to be mindful that from a rigour perspective the research process remained true to the principles of TACT. Within this representation below (see Image 11-2), reflexivity is considered within four components, inner space, outer space, the universe and reflexivity.

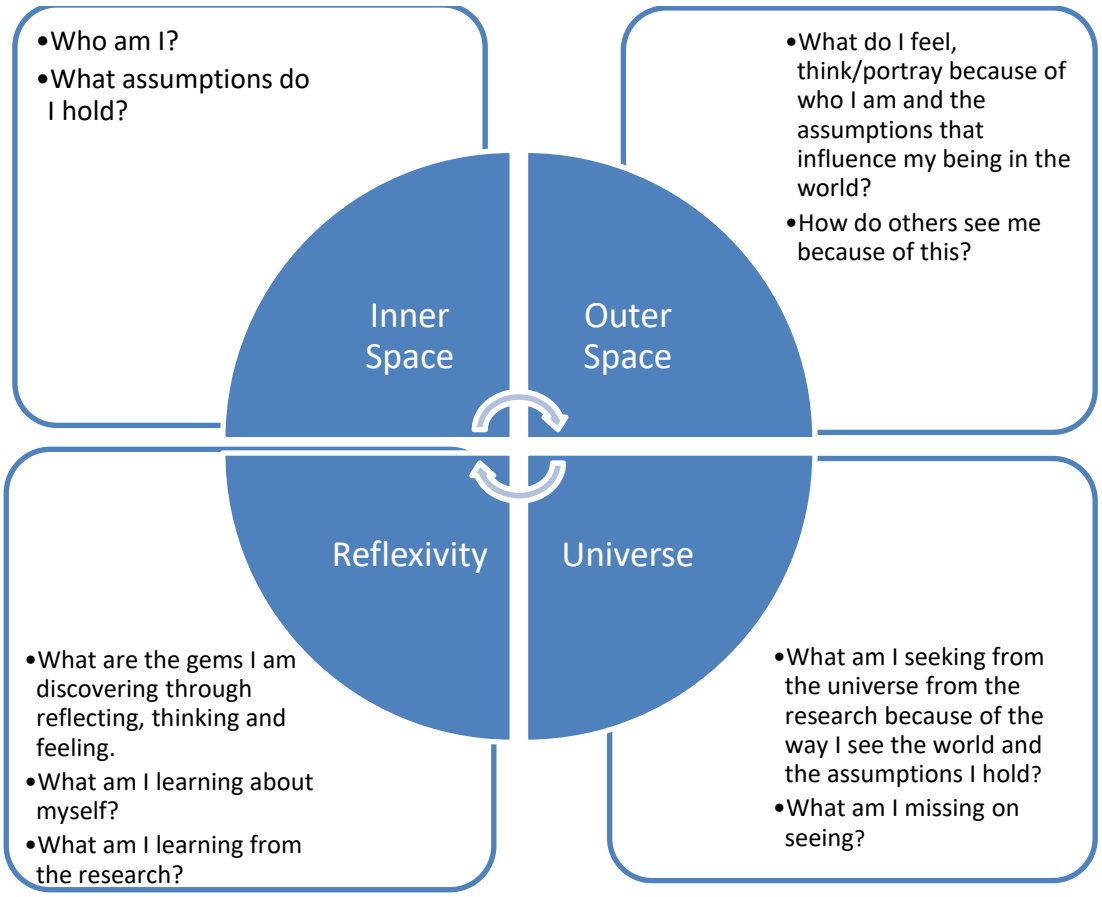


Image 11-2 Reflexivity for Researchers (2020)

The steps that form a reflexive process along a person-centred PhD journey will now be described in detail and utilised in the section below titled 'Outing Myself as a Person-centred Researcher.' The process for reflectivity I am proposing starts with an exploration of my outer space. For me, this involved keeping a creative journal as part of my field notes and using this as the basis for reflecting on me, as a person, starting with my personal ontology and then moving along the road through epistemology, the philosophical underpinnings of person and then to methodology. It was through this reflexive process where I was able to dig deep and learn about myself and understand at a deeper level how I see and understand the world. This provided some insight into the assumptions I hold, however, it also helped me to understand that I frequently came from an expert lens and I needed to move to a space where all of what I thought was reality were assumptions I hold. Being honest about my life journey and how this has influenced my values, required me to sit in discomfort and be truthful to my past experiences, both positive and negative. In saying that, having the courage to be

critically reflective is a positive foundation to begin a reflexive process and prepared me to authentically be in the research as my imperfect self. I found that by focusing on my personal ontology has enabled me to better understand myself and increase my inner space. I hope this resulted in me being more aware of how my inner space related to and influenced my outer space. Overall, the reflexive process where I considered my inner space may sound simple, however, in my experience, it was the reflective process that was confronting and dynamic as authentically considering myself below the surface of what I was comfortable to share, required vulnerability and required me to take off the armour I had built up over many years.

Next, outer space is where I explored the influence my assumptions had on the portrayal of myself in my language, actions and behaviours. I was mindful that my inner space impacts on how I show myself to the world and that the relationship between the inner and outer space was something that required continuous consideration for me to be authentic to the ontological, epistemological and methodological principles that I had created and needed to be acknowledged in my practice. I needed to portray my inner space authentically to the research participants and co-researchers through my language, actions and behaviours and having this courage, I feel helped me to develop my ability to be comfortable with being a person-centred researcher. Some of the participants shared a belief that they could hide their feelings from others in the mask of professionalism. I do not believe that we can authentically achieve this and when we do not present ourselves truly to others, we affect the development of healthful relationships. I believe it is when we present our imperfect selves to the world (Brown 2010) our outer space requires us to be truthful and authentic thus resulting in meaningful connections with others.

The model (see Image 11-2) then moves to the concept of the universe, where I believe the assumptions we hold and our experiences influence what we are actively seeking from the research information collection. I feel that this is because of what I hold dear and believe it influences my reality and how I see the world. I became mindful of how my outer space impacted om what I was seeking from the universe. I needed to remain aware of this to ensure I was not manipulating or predicting the outcome of the

research, rather allowing them to authentically emerge. The final part of the image (see Image 11-2) is achieving reflexivity which I believe is enabled by Dadirri inner deep listening and quiet still awareness. Using Dadirri as a form of contemplation allows for a deep connection to oneself and others through a connection to our embodied knowing (Ungunmerr 1988). Reflexivity in this sense refers to using contemplation to unearth the gems and learning that emerged from the process of reflecting, listening and feeling (Ungunmerr 1988). I hope these steps I am using may help other PhD candidates to consider how they can embed a process of reflexivity into their work in the future.

Outing Myself as a Person-centred Researcher

Moving to share what I have discovered about myself and my PhD research through a process of reflexivity, I believe has two purposes. Firstly, and most importantly, sharing my learnings from the breaks I took along my journey for reflexivity that contributed to the rigour within this PhD research. Secondly, as an example for others in the benefits and challenges of challenging myself as a person-centred researcher, to be vulnerable and reflexive in my way of being as a researcher. Reflexivity as a back-and-forth conversation (Finlay 2002) requires researchers to consider the principles and assumptions they hold, that influence their world view to a point of discomfort, creating awareness and appreciation for the assumption taken forward into the research process. In actioning the application of reflexivity, I undertook a process of exploration, creativity and reflection, this has come together in a creative journal that formed part of my field notes. I have shared parts within the previous chapters in my thesis, sharing and unpacking my assumptions and developing principles to take forward into information collection and synthesis. During the process of reflexivity, I have mindfully reflected against the principles I created in exploring my ontology, epistemology and methodology. The four tagxedos (see Image 11-3 Ontological Principles Tagxedo,

Image 11-4 Critical Realism Principles Tagxedo, Image 11-5 Epistemological Principles Tagxedo, **Error! Reference source not found.**) demonstrate pictorially the words which were emphasised in the principles I have outlined in the previous Chapter 10.

Image 11-3 Ontological Principles Tagxedo

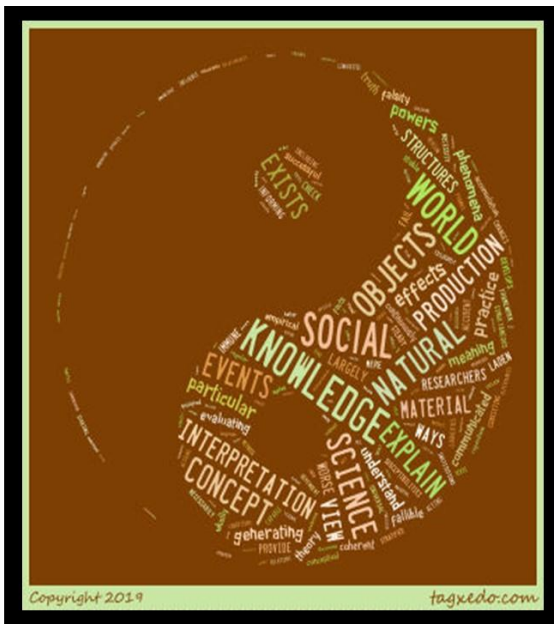


Image 11-4 Critical Realism Principles Tagxedo

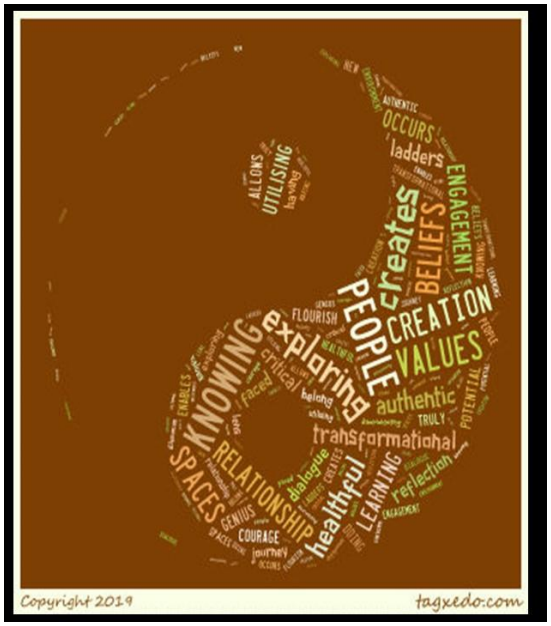


Image 11-5 Epistemological Principles Tagxedo

Image 11-6 Methodological Principles Tagxedo

The reflexive process of considering myself as a researcher focussed on my inner space. To gain an understanding of my inner space and begin to understand the relationship between this and how I show myself to the outer world (my outer space), I unpacked my way of seeing the world through the work of Kockelman (2013). I used

a creative approach from Kockelman's work where he describes self as a cloth that is soiled and stained from our life experiences, and that we need to explore self more deeply by considering the threads that make up the cloth. I used this analogy to consider the sum total of me and how this influenced me as a researcher where I identified the threads and impacts that the knots and frays have had on my perspectives and assumptions (Kockelman 2013). I have considered, both how I see the world and the nature of my reality, by exploring the ontological assumptions I hold as a daughter, wife, mother, sister, friend and nurse (see Image 11-7).

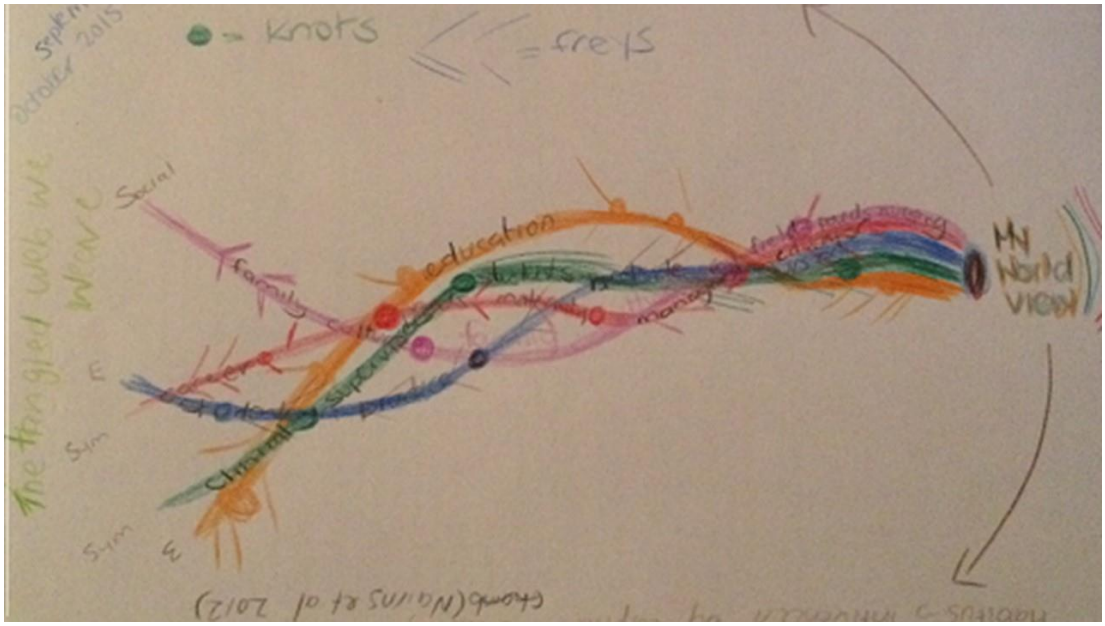


Image 11-7 Ontological Threads (2016)

I reflected on the challenge considering myself in this detail presented to me. This in retrospect was the beginning of a journey of self-discovery through discomfort and also one where I have grown both as a person and a person-centred researcher. My fellow PhD students in their publication 'Supporting transformational learning processes for person-centred healthcare research in doctoral education: a critical creative reflection' shared their challenges in sitting with challenges and how this enabled them to flourish (Rennie and Kinsella 2020; Sanders et al. 2020). I could relate to the experiences that were shared in these publications and found that writing this initial chapter on my personal ontology was a confronting, vulnerable and challenging experience. I can see from completing this that I started to learn to sit with discomfort

and that this was a lesson that was invaluable for me and my growth. However, at the time I was experiencing feelings of inadequacy and crisis, I was very close to leaving the PhD program and felt alone and scared. In unpacking this assumption that I was not enough, I discovered three learnings that have stayed with me throughout the rest of my PhD journey. The first was that I do not believe the theory of crisis as presented by Brian Fay (1987) is right for me and my way of wanting to be a PhD candidate. Crisis theory advocates that you experience a crisis and you need to sit with the discomfort until at some point you become enlightened, emancipated or empowered and realise how to move forward (Fay 1987). Instead of feeling enlightened, emancipated or empowered, I felt isolated and alone. It was in my search for moving forward that I resonated with Mezirow's (1990) transformational learning theory where he believes that you experience a disorientating dilemma and from this, you use critical dialogue and critical reflection to transform your way of seeing the world to gain a new learning perspective. I believe that the ladders of critical dialogue and critical reflection are kinder and more person-centred, and I feel they provided me with more support and enabled transformation (Mezirow 2009; McCormack and McCance 2017).

Secondly, I began to understand that person-centred research was messy and muddy and required researchers to be vulnerable and show their imperfect selves within the research. Moving along my PhD journey, the messiness and muddiness became something that I began to expect and embrace rather than move away from, as I did whilst exploring my personal ontology. My journey through the research process has unfolded through each chapter. I have used poetry at the completion of each chapter to creatively share my fears, learnings, and my growth. This started as a way of personal learning and soon became something that I looked forward to as each chapter was concluded.

Finally, I believe the support that I received from the Student International Community of Practice (SICoP) provided me with support and encouragement that helped me to believe in myself and begin to believe I was enough. This provided the encouragement I needed to continue with the PhD program. SICoP is a group I belong to as a PhD

candidate from the Centre for Person-centred Practice Research Centre, QMU, which is a community of practice for doctoral students and has a role in our learning and support (Saunders et al. 2020). I feel in SICoP I found a place to belong as a person and a student. It has been for me a place where I have made connections and relationships with others that I have found to be invaluable and I believe will continue to be significant in my personal life and PhD journey moving forward. Sitting with the discomfort of the disorienting dilemma this part of my PhD journey presented to me, has enabled me to undertake deep and rich learning about myself and therefore strengthened my inner space.

Moving along the road to my epistemological principles, I considered knowledge and how I have made sense of this in this research. I became more aware of the influence of the ontological assumptions I revealed on my understanding of persons, personhood and how this led to the unearthing of the epistemological assumptions that influence how I see the world. Related to the model of reflexivity (see Image 11-2), exploring my epistemological principles has allowed me to consider if the expansion of my inner space impacted on how I considered the development of my philosophical and theoretical principles, as I see this as the start of moving to my outer space. The underlying assumptions of the critical paradigm infer that the information collected that will inform the discoveries and recommendations that come from this PhD research will be relevant to the research context (students and clinical supervisors at the UOW, NSW Australia). The critical paradigm accepts multiple realities and acknowledges that whilst others may learn from the discoveries I make in this PhD research, it is not the focus or intent of the research, my focus is on learnings within the context of the research itself (Kivunj and Kuyini 2017). In my learnings about research rigour, the choice of situating this research in the person-centred space within the critical paradigm impacts on the concept of transferability (Daniel 2018).

The themes of learning through a disorienting dilemma (Mezirow 1978) and person-centred research being messy and muddy developing the theoretical framework that has underpinned this PhD research continued in this part of the reflexive process. The embodied knowing that emerged to create the theoretical framework that underpins

this PhD research came from a place of creativity. I again was overwhelmed with thoughts and feelings of uncertainty, fear and vulnerability. I, fortunately, had a fellow SICoP member visiting from overseas and she companioned me, holding space and providing the ladders of critical dialogue and critical reflection for me to move through (Mezirow 1990). She enabled me to consider the feelings I was experiencing and connect with my emotions to be able to create a theoretical model that I believe provided a solid foundation for this research and I hope will be useful in developing person-centred transformational curricula moving forward (Brackett 2018). Below is an image (see Image 11-8) from my field notes of the reflexive process we experienced together, pictured from left to right is Niamh Kinsella and myself. This experience for me demonstrated two key learnings, firstly that I have embodied knowing (that was and remains unknown to me) that can be unlocked by creativity and secondly that the value of SICoP in my PhD journey was an extremely rich environment that enabled me to flourish to my full potential. My hope in coming to the end of my journey is that I have given to SICoP some things that have helped others in the community of practice, as what I have gained is immeasurable.

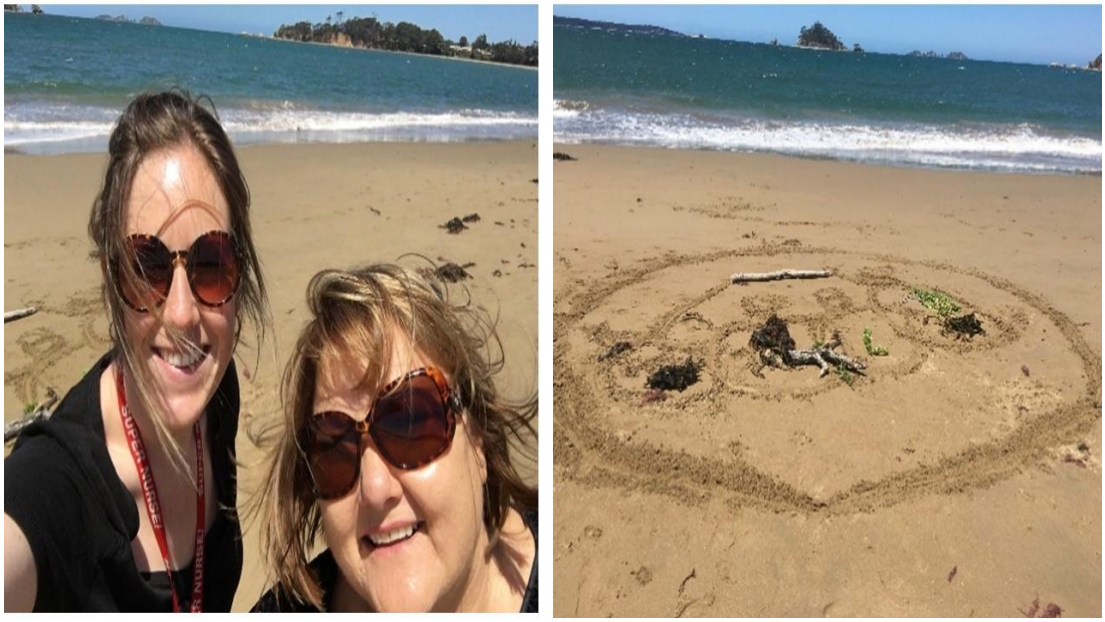


Image 11-8 Creating my Theoretical Framework (2017)

Next, in taking breaks throughout my journey for reflexivity, I now move this reflexive process against my methodological principles. In creating the person-centred

participatory methodological model that underpins the methodological principles I explore in detail below; I revealed the importance of inner deep listening and quiet still awareness for me as a person-centred researcher as well as for the participants and co-researchers. and how by immersing myself into the Dadirri poem, I was able to explore my assumptions about researching complex and multiple realities (Ungunmerr 1988). I was again presented with a disorientating dilemma (Mezirow 1978), as person-centred research is not a set process with instructions to follow, rather it is a complex and dynamic process that allows for multiple methodologies to be utilised (van Dulmen et al. 2017). I, therefore, developed my methodological model after again going through a process of reading, reflecting and challenging myself to engage with creativity. I found I was beginning to be more comfortable in this messy and muddy space and accepting of the state of discomfort. What I was acutely aware of was the need to demonstrate congruence and rigour.

Following the collection and synthesis of information with the participants and co-researchers, I have taken a break along the journey to undertake a reflexive process against each of my methodological principles. This stage of reflexivity brings together my learnings as a person-centred researcher with learning associated with rigour (Daniel 2018). Finlay (2002) considers reflexivity to be '… an ongoing conversation about the experience while simultaneously living in the moment" (Hertz 1997, p. viii). The conversations I have below I believe reflect the learnings and challenges that I have encountered as I lived through the collection and synthesis of the information collected within this PhD research.

1. *The persons who participate in this research have innately within them the ability to flourish to their full potential both as participants and as co-researchers.*

In co-designing this PhD research, I came with the assumption that persons as participants and co-researchers have the genius within them to flourish to their full potential. However, when I was feeling vulnerable and anxious about the information we were collecting and the synthesis that was occurring, I needed to continually remind myself that if I espouse this, I need to have the courage to live this assumption as my

vulnerability could influence my outer space and how I was engaging with the participants and co-researchers. This principle is reflected in my philosophical principles from the perspective that we all have the genius within ourselves and the ability to determine our own flourishing (Bhaskar, 2008) and the concept of human flourishing within the Person-centred Practice Framework (McCormack and McCance 2017).

I became mindful in the process of information collection, that I was challenged with being authentic to this principle whilst living this in the moment of the reality of the research (Finlay 2002). I was acutely aware that I was in a state of discomfort and concern that persons would not be interested in participating and the right information would not be collected. Interestingly, although I held an assumption that the clinical supervisors as experienced registered nurses would be happy to challenge me and be very critical in their synthesis of the information collected; in reality, it was not the case. It was, in fact, the students who were the ones who questioned and applied a high level of criticality. When I asked the students about this, they were confident in their response that they are paying students who have a voice and the right to use their voice. The clinical supervisors were also not surprised about this as they work with students in clinical practice and are used to working with students who are willing to challenge them and the practices they experience throughout a clinical placement. They themselves felt less empowered in the process as they felt out of their comfort zone in research and were comfortable taking direction from me, someone they perceived was an experienced researcher. The clinical supervisors also discussed being busy in their Doing as a supervisor and that reflection on practice was not part of their everyday practice even though they acknowledged it should be. In listening and learning to wait with patience, I realised that by waiting for the "right people to be present" and the "right time for the ceremonies and meetings" that the right information was shared plus I didn't mind waiting as it gave me time to reflect and be with the research (Ungunmerr 1988). I have argued in Chapter 4, that persons have the right to determine their own personhood. For me, this was an example of persons flourishing to their own full potential and reminded me to respect their individual and collective personhood.

The Dadirri poem (Ungunmerr 1988) spoke loud to me as I was full of worry due to the difficulty of issues associated with recruitment. I needed to be still, listen and learn patience, trusting the participants and the research process. I had a level of concern about the student group, that their competing demands of exams, work and family life would impact their ability to participate authentically. This was not the case, in fact, the active participation of the students at each stage of round two was exceptional and although they recognised their time challenges, they were one hundred per cent present in our discussion and were able to share their knowledge and understanding of the creation of relationships fully. Growth and development were evident in the students with two students suggesting the use of emoji reflection that was used in the research process should form part of the reflective process for all students during their future clinical placement. The supervisors shared that they also found reflection using emoji had helped them in considering their roles and enabled them the further develop themselves through increased awareness of connections with students and the importance of their role. I could see they were feeling more confident in their role and reflection for them was enabling a sense of flourishing in their role as a clinical supervisor.

If I consider this in the context of inner and outer space, I was concerned that my inner space anxiety would impact on what I was projecting in the outer space and thus influence the way I was seeking and therefore hearing and experiencing within the information collection and synthesis. I needed to not actively seek anything from the participant and co-researchers or the universe, rather allow the information they shared with me to flow organically. I became aware that before each interview and workshop, I needed to work on myself or my inner space and ensure I was in a calm and relaxed space, thus influencing my outer space. I used the following mantra ‘the universe will provide this research project what is needed.’ I believe each participant holds within them what they need to share, information that is rich and meaningful. I found that once I began conversations both with individuals in the interviews and with the groups in the workshops, I was easily able to be an empty vessel and that the information I was listening to was filling my cup. I was truly in awe of the wisdom that was shared by both groups of participants.

I felt that the participants in the part two workshops shared deep and insightful information during the workshop. I left feeling overwhelmed with delight and joy in the gems and insights that were revealed. I received words and messages from some participants and co-researchers that they had flourished after participating in this research. One participant, a clinical supervisor co-researchers *(part two workshop transcription)* stated, "initially I entered this research to help you, however as I began round two I realised this was no longer about you rather it is now about me growing in my role as a clinical supervisor". Another participant shared that they have grown professionally and personally on this journey. From a student perspective, a student participant *(part two workshop transcription)* stated "I went to my placement thinking I would respond in a certain way and the emoji helped me to see that was not the case. I learnt about myself, the growth and thinking will benefit me". I recognise that not all comments were this positive and I am aware there are issues of power (Habermas 1997), however, I felt participants were being authentic with me. I am so pleased that I have been able to experience this journey with each of them and see their growth. The wisdom, vulnerability, and insight shared with me as part of this research were more than I expected, and I have been left in wonder about the participants and co-researchers' self-awareness to dig deep and unearth their embodied knowing.

In ensuring that I was authentically demonstrating that I believed the persons who participate in this research have innately within them the ability to flourish to their full potential both as participants and as co-researchers, I was also being mindful of the related elements of rigour. This principle is related to trustworthiness, auditability and credibility (Daniel 2018). To ensure trustworthiness was evident in the information collection, I needed to be open to hearing what the participants and co-researchers were saying and validated with them from a credibility perspective that I had interpreted their information correctly. I also kept field notes and used recordings and exact word transcription for auditability of any discoveries that emerged.

2. *The people who participate in this research have the right to authentically participate in this research in the way that is right for them and they maintain the power to change their contribution at any point within the research process.*

The ethics application considered this principle and provided the guidance for ensuring information is shared with all potential participants in their decision to join the research. All participants within the PhD research willingly volunteered their participation and have actively engaged with all requirements of the research. Each group (students and clinical supervisors) has been conducted separately and they have not interacted with members of the other group in any way concerning the research information collection and synthesis. There has been no involvement in any of the research team in the allocation of students or clinical supervisors for clinical placements. The allocation of clinical placements was and is undertaken by university professional staff in a separate organisational unit to the academic staff involved in the project. This principle is underpinned by the concept of agency and power within a social relationship. In this research for this to become a reality, the principle requires the creation of safe spaces, a philosophical principle in this PhD research (Habermas 1987).

Within each participant group, we discussed authenticity and together created ways of working to enable the groups to work in ways that were true to their values and themselves as persons. We also discussed within each group, the concept of power and the need to acknowledge this as power over, power with and positional power (Brown 2018). Having an honest discourse about the implications of power and the potential to impact on authentic participation was a requirement to acknowledge power within the group. It is my assumption that power as described by Dewing et al. (2017) in the *Person-Centred Healthcare Research* book is always present in researcher relationships and to acknowledge this we talked about this and explored the impact of power from all our perspectives. I remained aware of my biases which have been described as my assumptions, I was aware of the need to attempt to manage this and in my inner space so as not to show this in my outer space. In line with this, the issue of trustworthiness in regard to bias from a rigour perspective was important to

contemplate. I consciously attempted to acknowledge and manage my biases within my inner space so as to minimize their impact both on my outer space and in what I was seeking from the universe.

I started the research information collection process with the assumption that we had processes in place as part of the ethical approval so participants would be aware of their right to participate in the research in a way that was right for them. I was also aware this assumption did not address the power differential that exists between academic staff and students and clinical supervisors and in reality, I needed to listen and develop patience rather than hope we had put all we could in place to address power. I realised towards the end of the information collection that creating safe spaces was a conduit for the students to have a voice and be authentically present (McCormack and McCance 2017) within the research.

My discomfort in this principle was that I feared students and clinical supervisors would either not be interested in participating or have too many competing demands to authentically engage with the research. I was aware of the need to actively work on my inner space so that my anxiety was not evident in my outer space and interactions with the participants and co-researchers. Although the number of participants was lower than expected, those that participated were highly motivated, authentic in their participation, and able to analyse information well above what I expected for a Year 1 student. Our research space became an online space unexpectantly and this came from listening to one another and providing the flexibility that suited the participants and co-researchers. Overall, my learning from this is that being authentic in my own participation as a person-centred researcher required me to approach my interactions with the students and co-researchers with an openness to listen and be patient. This principle was very important to me in the recruitment part as I found that my disappointment within my inner space about the low number of students willing to participate did impact on my feelings about the value of this research. Rationally, I knew that students were overwhelmed with the academic session finishing, having assessments due, a busy placement period quickly approaching and the looming of the exam period only one month away, plus the impact of a very stressful fire season in

our region. Consciously, I fully respected the demands students had upon them, however in my inner space was overwhelmed with my need to have enough participants to volunteer. I felt I created a level of anxiety for myself that was evident in my outer space. To manage this, I undertook critical dialogue with the other academic staff who were supporting me in the recruitment of participants and workshops to ensure that I was sending messages to remind students of the opportunity to participate rather than bombarding them with repeated messages. I did receive many messages from students, thanking me for the opportunity and wishing me well however declining the opportunity due to their other competing demands. I respected their right to not participate and acknowledged all emails with well wishes for their placement and upcoming exams. For the clinical supervisors, their rapid response and agreeing to participate was reassuring of the value of the research and I was very pleased that so many potential participants were interested in being involved. Moving forward, I needed to remain mindful that each round will have different groups of participants recruited and therefore I needed to let go of any assumptions and not seek similarities from round two. Working on my inner space, I spent time contemplating the virtues cards (Virtues Project 2020), revisiting my methodological principles, reading over the Exploring Person-Centred Methodology, Chapter 6 and ethics application to ensure I reset my understanding and the perception that this was a new group of participants with their own unique contributions to add to this PhD research. I was able to achieve increasing my inner space and therefore, manage what I was showing in my outer space and seeking from the universe in round two.

This principle also had a particular significance in part two of the research with regard to the bushfires in our local area. Australia and the NSW South Coast faced unprecedented bushfires in December/January 2020 and the impact of the bushfires on the ability of the students, in particular, to participate, was significant. I received (via email) a very emotive message from one participant that I do not think was personally directed at me rather her expressing her frustration with the impact the fires had on feelings of safety and ability to earn an income over this time.

> I'm sorry I can't attend there is just so much going on here with this fire that is slowly hunting us here. This constant state of flight or fight not knowing what you will wake up to after a few hours of sleep has taken its toll not only physically but mentally. There is also the financial impact it has had on those of us who are self-employed there's not much left in the tanks.

I assumed that potential participants for part two were all affected in some way from the bush fires. There are some that were directly affected while others were indirectly impacted, and I believed that I needed to be considerate of participants feelings of anxiety and safety even more than previously in part one. I made adjustments to all email correspondence in an attempt to provide the participants with a level of reassurance that they had the choice to participate or not and the choice of this was at their discretion and their decision would be fully supported by me as the principal researcher. Post the bushfires was a significant period of rebirth for all of us. A strong message for me following the bushfires was the power in recovery and rebirth and that this is possible even after such a disaster. Taking time for inner deep listening and quiet still awareness was a healing process that gave us a rich and deep understanding of ourselves and our surroundings. Below are a few photographs (see Image 11-9) of my property as a way of placing perspective on the severity of what we all were experiencing.

Image 11-9 Bushfires in South Coast NSW

As stated earlier, issues related to power, coercion and my position, concerned me during recruitment within this round two. Once participants chose to participate as co-researchers, I believed they were comfortable with their decisions. In the process of recruitment, the clinical supervisors were quick to respond, and they were excited by the opportunity, however the students were slow and anxious with their responses and I asked the recruiter to resend the email on three occasions. We talked about this in detail, as it was the day before recruitment was closing and there were only two responses, the final two responses came on the last day. I was concerned that by resending the message that I may be moving from requesting participation to being coercive. After talking with the students who participated, I felt much more reassured that they were participating freely, and they also gained something from the PhD journey that added value to their educational experience and their consideration of nursing practice in the future. I was also personally affected by the fires with my property being burnt and my local community being one of the worst affected, I did not want to burden the co-researchers with my issues however many asked me personally about my situation and I needed to bring a level of authenticity in my response. Being with this group of amazing students and clinical supervisors helped me not only in my PhD research but also my personal journey through this time. I felt a sense of rebirth and deep gratitude to all who had been involved in helping me to gather information and synthesise the meaning from their perspectives.

3. *The people who participate in this research have the courage and curiosity to explore the layers of the relationships they develop during a clinical placement considering how these impact on their ability to realise human flourishing.*

I never doubted that the people who participated had the courage and curiosity to explore the relationships however I did doubt at times if the information tool provided would enable this to occur. The ability for each participant to experience human flourishing is multi-factorial and I hoped that an exploration of emotions in developing relationships may have enabled me, the students and the clinical supervisors to have sparks of healthful learning that come together to form a new learning perspective (Mezirow 2000). These sparks forming a pattern is what leads to human flourishing.

This methodological principle sits within the work of Maya Angelou with the concept of belonging from the perspective of freedom that is threaded through the ontological, personhood and philosophical principles of this PhD research (Angelou and Elliot 1989; Brown 2017).

I had concerns about the use of emoji as a process for exploring emotions in a healthful relationship. My concerns were founded in the fact that the use of emoji as a research information collection tool is not well supported with evidence (findings from Scoping Review, See Appendix G) and therefore by trying something new I was taking a risk. After taking time for contemplation and inner deep listening (Ungunmerr 1988), I felt much more comfortable that it was a powerful way to help both students and clinical supervisors explore how they create and manage supervisory relationships. As I listened to the interviews I wondered if I was hearing and sensing the right things. I realised as part of this process I needed to let that go and connect with my own vulnerability and allow the participants to explore their relationships and the discoveries would emerge in their own time. As I write this, it seems quite logical however in living this experience, I experienced doubt, uncertainty and fear. The overall outcome was as I would have expected that the participants gained from this and shared what was right for them and what they felt was valuable and in the end, the outcome was one that was powerful and informative. Once again, I found myself as a person-centred researcher in this phase full of doubt and discomfort. I now see that this was normal in experiencing research as a person-centred researcher, as I was experiencing the control of information being taken from me and placed with the participants and co-researchers. I was continually surprised at the vulnerability that came with being a person-centred researcher. Looking back, I am convinced that I needed to be open to learning and live with the discomfort as I grow as a researcher.

I wondered if there is a certain type of person who volunteers to participate in research and that I may be missing out on some viewpoints, however, I also understand this is outside of my control and that I need to focus on those who voluntarily agreed to participate. I believe as a person-centred researcher, I have developed the ability to trust that persons have within them what is required for them to learn and flourish to

their full potential. I remained mindful of not influencing participants' worldview rather being inclusive of the variety of worldviews. I believe being open to the process of unlocking what is required is something that I have developed over time, however, I am aware that I am more comfortable in truly believing this in a learning environment than a research environment. In unpacking this, I asked myself the question, if I truly believe this why was I concerned that the information I was collecting may not be enough? On reflection, I know it will be enough and doubt comes from a place that I want my PhD studies to contribute to what is known about facilitating learning in a non-classroom setting. Therefore, I'm placing an unrealistic pressure on myself that creates a sense of doubt. I purposefully entered each encounter whether it be in email, face to face, or over Zoom, with a conscious inner space of acceptance and belief that all persons are doing the best they can. I was hopeful this belief would influence my outer space and show I believe in each person or group I was interacting with (Brown 2018). Believing persons are doing the best they can change how we show up and interact with others.

It was evident again that students were more able to process information quickly and respond to complete a task within the research. I found the depth og learning the clinical supervisors' demonstrated was greater than in the initial round, however, they needed more time to process information and collectively work together to agree on their overall synthesis and learning. A key learning for me has been not to worry about the time it takes for a group to analyse and synthesise information, rather to have the patience to allow this to organically occur and to understand that participants achieve the outcome if as researchers we do not actively seek from them what we are looking for. I realised that by believing in myself I, therefore, am able to believe in others. My need to control the outcome and its effect on others is something that I have recognised. However, it is something that I have come to terms with during this journey.

I feel the practice of reflexivity that I have undertaken has gifted me the tools to become consciously aware of the relationship between my inner and outer space and its overall impact on how I was influencing the research by unconsciously seeking things that were not mine to seek from the universe. Working on my inner space has

been beneficial to me and the research as well as the practice of detachment. Detachment comes from the Virtues Project as a process that "allows us to be in the world but not of it" (Virtues Project 2020). I have permitted myself to be in the research and part of the process while letting go of the feeling that I need to control the outcome. I believe this enables participants and co-researchers to be in the research and have the best opportunity to reveal what is true to their inner knowing. At each point in the research process, when I took breaks for reflexivity, I found that I was overwhelmed with a sense of awe for the persons who participated in this research. I had great respect for the trust they placed in me and gratitude for what they shared with me. The Dadirri poem ends with "I believe the spirit of Dadirri that we have to offer will blossom and grow not just within ourselves but our whole nation." I had a sense that the participants and co-researchers had the opportunity to flourish from being in this research, I can only speak for myself and I know I have flourished through my experience.

4. *That all turbulence in clinical practice has the potential to transform into purposeful turbulence enabling students, clinical supervisors and academic staff to realise belonging and transformative learning.*

This principle describes the messy and muddy nature of person-centred research. I began my contemplation (Ungunmerr 1988) in part one round one, listening to my original definition of turbulence in the Exploring Person-Centred Methodology, Chapter 7, where I described the difference between turbulence and purposeful turbulence, and I considered the health care context as the conduit for where purposeful turbulence could create active learning. This initial part of the research was where I began to listen and wait with patience. Purposeful turbulence relates to my philosophical principle of transformational learning as this is where I have engaged actively with learning to transform our understanding of concepts and the way we see and understand the world (Mezirow 2000). I hold the assumption, that all healthcare contexts have turbulence and passive learning occurs in this chaos. It is by transforming this chaos into purposeful turbulence that learning through the crafting of healthful relationships. A learning for me is that person-centred research is messy and muddy and therefore turbulent. The turbulence in research as part of my PhD, became purposeful turbulence as the students, clinical supervisors and myself crafted

healthful relationships with each other and supported each one of us to seek our full potential. Consideration regarding rigour is important within this principle as concepts of auditability and keeping comprehensive field notes, and credibility while staying focused on the synthesis in accordance with ethical approval and taking time for triangulation and member checking can get lost in the turbulence.

Purposeful turbulence in person-centred research is where there is an ability to consider something you find uncomfortable or challenging, live with that discomfort and then use critical dialogue and reflection to help turn the experience into a positive one. Many participants in both groups talked about the value of critical dialogue and how the use of emoji has increased their ability to be reflective and truly consider their role in creating relationships and subsequent learning. In particular and significant learning for me, has been how we often take for granted the movement in purposeful turbulence as being the conduit that transforms the experience from being one of challenge and discomfort to a positive experience. I have now become more consciously aware of this in my daily practice as a facilitator of learning and researcher. This is a learning for me, that I believe will influence many aspects of my life and my way of being in the world. I now passionately believe that learning through purposeful turbulence comes from engaging in critical dialogue and reflection.

5. *That contemplation is embedded into the Knowing, Doing and Being as a participant and co-researcher in this PhD research.*

For me, the power of Dadirri is ever-growing. I find the concept of deep listening and quiet still awareness to be one that now infiltrates my life, my work and my research (Ungunmerr 1988). This PhD research has Dadirri as a concept meshed through it and for me from a philosophical principle perspective, Dadirri sits within Mezirow's (2000) concept of transformational learning as the poem has a strong message of struggle and rebirth. I feel that I have grown as a person-centred researcher though the discomfort or struggle of undertaking this PhD research. I also feel I have witnessed growth in the participants and co-researchers as they have grappled with the challenge of authentically contributing to research in the reality of practice. The poem and its words hold such strong meaning for me and now influences my way of being in the

world, in a way that I would have never thought possible. A colleague and fellow PhD Candidate said to me – 'you cannot make everything into Dadirri'. My response was 'why not'. I have read the poem so many times I could not recall the number, and each time I read it, the poem speaks so profoundly to me. The challenge of accepting the way people are and being open to this and hoping eternally that they will accept your way of being in the world speaks to me in that we need to remain always the learner and open to hearing and new ways of understanding.

One participant who was a student said within their transcript that we should take some time for deep listening and quiet still awareness as a usual practice while on clinical placement and adopt the use of emoji for all students and clinical supervisors. Another clinical supervisor participant indicated that taking the time to consider her emotions each day has helped her to better connect with the students in a more meaningful way. The impact of the contemplation (Ungunmerr 1988) of deep listening and quiet still awareness with emoji excites me as I heard and felt the impact this had on the experience of the participants and co-researchers. I now am aware of the assumption that taking time for deep listening and quiet still awareness contributes to the creation of healthful relationships. After taking time to listen and wait with patience, I can now assert that using emoji within a reflective process further enhances the development of these relationships. Dadirri is something that helps me manage and positively fill my inner space and thus allows me to portray my authentic self within the research. I believe that by practising Dadirri, I am in a space where I am not seeking from the universe rather, I am open to what the universe has to offer to me. I saw co-researchers reach a level of insight that took my breath away and I felt so privileged to be part of the research and share the journey of others.

Conclusions for My Practice as a Person-centred Researcher after Information Collection and Synthesis with Co-researcher

At the end of the process for information collection and synthesis with participants, through reflexivity, I have made significant learnings about myself and my growth as a person-centred researcher. I feel that I entered this process with some consideration that it will be challenging, however in reality I now believe it is only through the

experience of undertaking the research that you are able to truly challenge yourself in the being as a person-centred researcher. I hope I have now accepted feelings of vulnerability and uncertainty are part of being in the research where the participants and co-researchers are the ones who have the gems that need to be identified and polished. I have definitely become more aware of the elements of a healthful relationship however, more than that, I have become so much more aware of who I am as a researcher. The consideration of me and my inner space is a true gift that is something I have explored and will impact on my way of being in the world. My place in the research was as it should be, I was at times directing recruitment, facilitating conversation but mostly listening and learning. I have referred to my space in the research as the third space and I now have a new learning perspective where I believe that there is a unique space where a person-centred researcher can fit.

In summary, I have challenged myself to remain open and vulnerable as a researcher. I feel more comfortable /and confident / in my development as a person-centred researcher from this experience. The learning I have discovered about the role of vulnerability as a person-centred researcher has been valuable for me both as a researcher and as a facilitator of learning. If I consider the Knowing, Doing, Being and Becoming parts within myself as a person-centred researcher, my journey has been an interesting one that has been filled with doubt and challenge but also had abundant wisdom and joy within it. Staying true to the ethics application and ensuring I do no harm to others has been at the forefront of my mind as a researcher. I am mindful there is a balance in offering opportunity and moving to a space of coercion. I remain grateful for the time of the participants and co-researchers and thankful for all they have shared.

Reflexivity Following Discoveries Through Synthesis

As I come to the end of synthesis and move to bring my thesis together, I am taking a break for reflexivity and to consolidate my learnings from the synthesis and meta-synthesis of the information. Reflexivity has been defined within this chapter and although it for me is a conduit to learning, it is also a confronting process which requires an introspective look at myself. In how I have described reflexivity as a

process, starting with the inner space requires, honesty and a connection to feelings and emotions. This connection to emotion then influences our outer space or what I am showing the world and finally the universe or what I am from the research. This symbolises for me an exciting and scary time in this PhD journey as I have never really believed I could get to this point. I am eternally grateful for the support, encouragement and belief from my research supervisors that I can do this. At many points in this PhD journey, I believed I have reached a point where I have grown and moved forward and thought I will now be more confident. The reality is that there is a new challenge at every next step, and that challenge brings about the fear, doubt, and concern required to enable further learning. Ungunmerr (1988) refers to the vulnerability and resilience required for growth in the Dadirri poem in the paragraph below:

> We are like the tree standing in the middle of the bushfire sweeping through the timber. The leaves are scorched, and the tough bark is scarred and burnt, but inside the tree the sap is still flowing and under the ground the roots are still strong. Like that tree we have endured the flames and we still have the power to be reborn.

I feel this represents the journey of the person-centred researcher. There are many times I have experienced a sense of being scarred and burnt through the process of writing and information collection and synthesis however, each time I have gone back to Dadirri and used inner deep listening and quiet still awareness to have the power to be reborn. In some ways, this refers to the reflexive process I undertook in creating my ontological principles in Discovering Me and My Ontological Values, Chapter 3. Keeping the spirit of Dadirri alive in me has been where I have learnt to use my discomfort to deepen my understanding and grow as a person-centred researcher.

Moving to the process of the discoveries, I again was very conscious to work on my inner space with compassionate self-care. There is a part in the Dadirri poem that states: “Careful preparation must be made. We don’t mind waiting because we want things to be done with care” (Ungunmerr 1988). A teachable moment from this for me is that I need to ensure that I remember to care for myself first as I am the first link. By the first link I mean, I need to feel care for to have the capacity to consider others. By Doing this I am caring for my personal inner space. Being in the position where I have listened to the needs of my inner space and where I feel cared for, I am better

able to influence my outer space. The relationship between the inner and outer space is important to consider if as a person-centred researcher I want to remain open to listen to and hear the words of the participants and co-researchers. Having clarity in what I am hearing and not seeking the information that makes me feel cared for allows me to authentically combine the student and clinical supervisors' information collected and use my voice to create a shared understanding. Being compassionate to myself became even more important as we had just experienced the 2020 bushfire and moved into COVID-19 isolation and restriction. I used this time to eat well and exercise more, I used the practice of daily yoga, and the virtues cards to keep an optimist outlook on the challenging situations that we were all living in. The card of optimism spoke to me not just for my personal wellbeing but also for me a person-centred researcher growing in my understanding of what the information was helping me to discover. The virtues card of optimism defines the practice of optimism (Virtues Project 1990) as:

> I have a positive viewpoint
> I have faith in all circumstances
> I trust in positive outcomes
> I focus on solutions rather than problems
> I see a brighter future
> My hope is resilient

Moving on with the Dadirri poem "Listening should go both ways. … We keep longing for the things that we have always hoped for, respect and understanding" (Ungunmerr 1988). I feel this is representative of inner space, I opened my mind and heart and listened to all five groups of information so that I could in my outer space, bring respect and understanding to the words spoken by the participants and co-researchers.

The final consideration in the reflexivity model is the universe, my hope was that the work I had been undertaking to maximise my inner space and thus control what my outer space revealed to the world, was enough to limit what I was seeking as a person-centred researcher from the information collected (or the universe). I was acutely

aware that my biases and assumptions could impact on what I saw and heard through the information synthesis. I needed to consider the TACT Rigour Framework and ensure there was congruence in my research discoveries, and I have described earlier in this chapter how trustworthiness, accountability, credibility and transferability were applied. I revisited my ontological, epistemological and methodological principles several times whilst examining if the research discoveries were congruent with the information collected. I have shared my creative reflexive process that I undertook throughout this PhD journey in the chapters of this thesis. For me, this has been a creative way to express my feelings and learnings as I developed as a person-centred researcher. The message I'm sharing with the universe was one of my epistemological principles, persons have the genius within them that allows them to flourish to their full potential, and therefore the hidden discoveries revealed were situated within the publications and transcripts from this PhD research. I read the Dadirri poem in full regularly and sat in contemplation (Ungunmerr 1988). The message I took from the poem in what I was seeking from the universe helped me to remain open to hear and feel with a free mind, "We don't worry. We know that in time and in the spirit of Dadirri (that deep listening and quiet stillness) the way will be made clear" (Ungunmerr 1988). As a result of sitting in contemplation, the discoveries I found are representative of my amazing and insightful participants and co-researchers.

Chapter Summary

In this chapter, I have considered research rigour using the TACT Framework (Daniel 2018), created a model for reflexivity and considered my growth as a person-centred researcher through a process of reflexivity. I considered the complexity of research rigour in qualitative and more specifically person-centred research. Consideration was given to ensure the discoveries made were congruent with the overall ontological, epistemological and methodological principles developed as part of the PhD research process. I then moved on to explore the term reflexivity and I have argued this term is frequently used in academia, however it was not well understood or applied. The definition of reflexivity that I have developed to explore my learnings as a person-centred researcher is that reflexivity is a dynamic process where I challenge the assumptions that have surfaced as I explored the underpinning ontological,

epistemological and methodological principles of this PhD research. I bring together the reflexive nature of the work across many chapters and discuss these to share my learnings as a person and a researcher. In this chapter, I have demonstrated that as person-centred researchers, we need to consider our inner space and work on understanding our values and beliefs and bringing them authentically into our research with our participants and co-researchers. I also argue that to maximise our inner space and manage what we portray to others in our outer space we need to care for self and ensure we bring our assumptions to the surface kindly. It is in how we respect and understand our assumptions enables us to person-centred research authentically. I conclude this chapter with a final realisation that I have learnt to become comfortable sitting in the discomfort of person-centred research.

This chapter leads to the end of the PhD journey, Chapter 12, where I bring together the key discoveries and consider the future impact that this PhD research could have on the development of healthful relationships and person-centred transformational learning in the practice context. This final chapter in the thesis advocates for nursing as a profession to have the courage to embrace a way of Knowing, Doing, Being and Becoming in practice that facilitates future nurses to be instrumental in creating person-centred learning cultures.

Chapter 12

The End of the PhD Journey – Key Discoveries and Future Roads

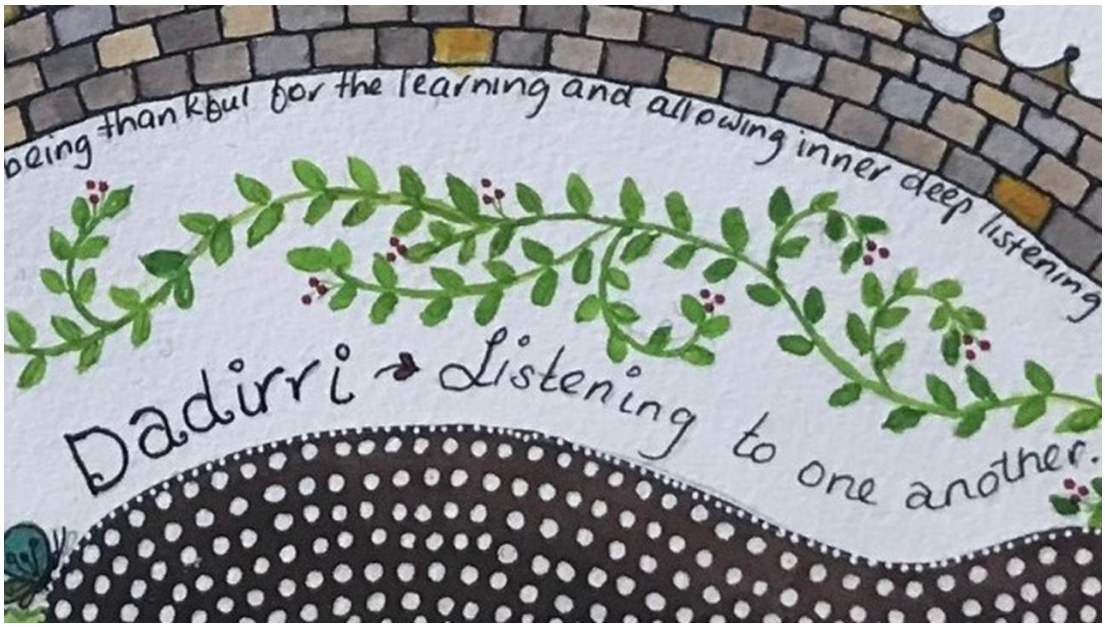


Image 12-1 Taking Breaks for Rigour and Reflexivity - © Maria Mackay 2020

Introduction

The synthesis and meta-synthesis chapter within this thesis provided the discoveries that surfaced for me from my experiences and the information collected within this PhD research. The image (see Image 12-1) above demonstrates the time to pause, contemplate and consider the key learnings I have discovered along this PhD journey. Further, a creative meta-synthesis revealed the key discoveries explored below in this chapter. In essence, I started at the beginning of the road again and considered how I now understand this information from my new learning perspective (Mezirow 2000). I am sharing my transformation, from being the person I shared in my ontology to how I have emerged towards the end of the road on my PhD journey. I have highlighted my sparks of healthful learning and walked through how these sparks have come together, ignited and transformed my understanding of my research question – How do healthful relationships between students and clinical supervisors influence transformational learning?

This chapter follows the road of my PhD journey, the image (see Image 12-2 below), and as described in Chapter 1. This picture represents for me the imperfect journey I have taken through the messy and muddy pathway to Becoming a person-centred researcher. The journey to Becoming a person-centred researcher is my emergence as a novice researcher. Although I have come to the end of this journey, it starts another journey for me, that of moving into starting the journey of an early career researcher. An early career researcher at the university I work at is defined as someone who has completed their PhD in the last 5 years.

Image 12-2 My PhD Journey - © Maria Mackay 2020

I come to the end of this research journey with the hope that my research will influence the future development of person-centred curriculum. Taking a person-centred approach to curriculum development requires academic staff to be open to learn, unlearn and relearn and presents both challenges and rewards. My hope is that this research study will influence what is understood about person-centred curriculum development in the non-classroom setting, by challenging some existing views of the importance of healthful relationships and how they influence person-centred transformational learning. Consistent with critical paradigm research, the learnings from this may be helpful to other contexts, however as explored in Chapter 6, that was

not the primary intention. I recognise that change is a process that requires patience. My wish is that those who are aligned to crafting healthful relationships are able to influence further the development of person-centred transformational nurses for the future.

I will now explore each of the learnings or key discoveries in detail, demonstrating how each spark of healthful learning contributes to my new learning perspective. I then bring these together and provide a succinct overview of the key learning. Finally, I bring the chapter to an end with the recommendations to provide the focus for future research.

Ontological Key Discoveries

Within the exploration of my ontological threads that I have described in Chapter 3 and further considered in Chapter 11. I have demonstrated my two key ontological discoveries, vulnerability and connections to my Aboriginal culture through Dadirri. The image below (see Image 12-3) denotes the exploration of the threads that make the sum total of me (Kockelman 2013) that was undertaken early in my PhD journey as part of Chapter 3.

Image 12-3 Ontology on the PhD Journey - © Maria Mackay 2020

The first key discovery along this PhD journey was that allowing ourselves to feel and have the courage to experience vulnerability supports authentic human-to-human connections. Brown (2012, p.34) defines vulnerability as: "…uncertainty, risk, and emotional exposure." She further expands on this, arguing that if we spend time protecting ourselves from feeling vulnerable, we limit our ability to flourish. Those who see vulnerability as weakness are argued to be allowing their fears and lack the courage required to embrace authenticity and vulnerability (Brown 2012).

I began to gain a sense of the significance of vulnerability during the Student Led Project (See Appendix D) outlined in Chapter 5. The students in the student led conversation research project shared that from their experience showing their vulnerability to their clinical supervisors was influential in the creation of more human-to-human connections. A discovery from the information collected in PhD research was that human connection enabled all persons involved in the relationship to see the person behind the title. This was defined within the context of a healthful relationship as respecting personhood.

Through this PhD journey, I have gained a new learning perspective on vulnerability. I now hold the assumption that connecting on a human-to-human level and demonstrating vulnerability is an integral part of being a person-centred researcher. In all honesty, at the point of writing my ontology chapter, I was so overwhelmed with the challenge of undertaking PhD writing that it was some time before I realised the impact of making these connections. By exploring my personal ontology and considering how I see the world, I now have gained a new way of seeing the world (new learning experience) (Mezirow 2000) along the road of this PhD journey. I was in the midst of a disorientating dilemma where I felt inadequate to be a PhD student. In allowing myself to feel vulnerable, I will forever be grateful that I was encouraged to sit with my discomfort, consider what the teachable moments were and emerge with a new learning perspective.

My second key discovery along my PhD journey also came from Chapter 3. This discovery was that connecting emotionally to my vulnerability as a person-centred

researcher has enabled me to link to Dadirri. Confronting vulnerability allowed me to meld the values of my culture to Dadirri, to facilitate an openness to learn and unlearn and relearn. The power of the Dadirri poem and its contemplative practice, embedded the practice of Dadirri as my way of being a person-centred researcher. Within Chapter 3, I commented that sharing my story felt empowering. I had no concept of the impact this at the time however, as I moved along the journey, I have learnt that demonstrating vulnerability was challenging however also the conduit to my growth. I had utilised the poem Dadirri (Ungunmerr 1988) previously in my work and research, however, my relationship to the poem and the concept of inner deep listening and quiet still awareness has strengthened throughout my PhD journey. I believe Dadirri has become embodied within me as a person and researcher.

After listening to the wise words of Aunty Miriam-Rose Ungunmerr in a webinar, I wrote this poem to express how Dadirri influenced me from the beginning to the end of my PhD journey:

We walked together – participants co-researchers and myself,
We listened to each other and learnt from each other,
We practised reciprocity to be authentic,
Researching together was a gift,
An opportunity to walk together, and truly hear each other,
In Doing this we enabled each of our voices to be louder,
We nourished our inner space through Dadirri,
It connected us to each other.

Personhood Key Discoveries

My third key discovery along my PhD journey came from Chapter 4 and was about recognising that the tension that exists for nurses in our profession is due to the lack of understanding of our collective nursing personhood. The concept of nursing personhood came to me through my anecdotal experience of experiencing nurses being judgemental and unsupportive to students. I began to wonder why it is that we cannot embrace novice nurses rather we judge them against what each of us individually perceives a nurse should look like. Nursing personhood for me, relates to my ontology

as well as my understandings associated with the Aboriginal perspective of communal personhood. Personhood from an Indigenous Australian perspective focuses on the concept of wholism is inclusive of spirituality from an Aboriginal sense which encompasses connection to the "natural world, human society and the universe" (Grieves 2009, p. 3). From an Aboriginal sense, spirituality relates to the "ontologies (ways of being) and their epistemologies (ways of Knowing)" and ultimately to their perception of personhood (Grieves 2009, p. 1). In addition, "the nature of Aboriginal philosophy suggests that solutions that lead to the legitimising, strengthening and promulgation of Aboriginal Spirituality, and notions of personhood, including collective approaches, are likely to produce real outcomes and enhance wellbeing" (Grieves 2009, p. 5). With regard to nursing personhood, I believe that if nursing as a collective understood their professional personhood, we would be more likely to accept individual differences. Having a collective understanding of our profession frees nurses from the need to compare a student to themselves and gives them a holistic perspective to accept difference and enable individual personhood.

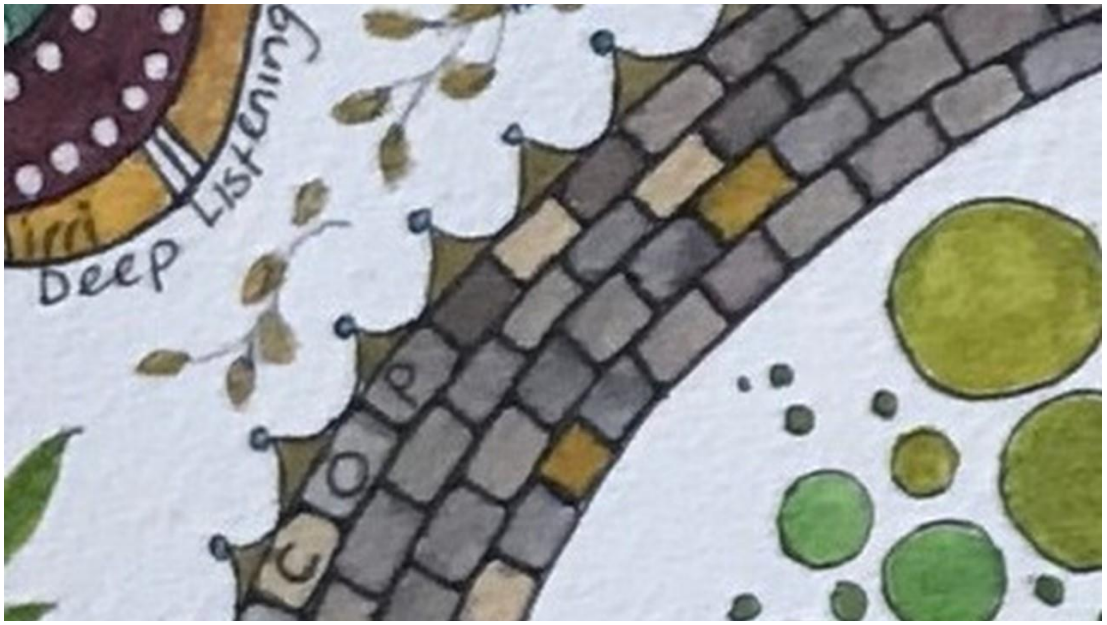


Image 12-4 Personhood on the PhD Journey - © Maria Mackay 2020

The above image (see Image 12-4) represents me finding my personhood and sense of belonging. It has the words SICoP and a range of peaks that represent the persons within this group. SICoP gives tribute to the special connections I engaged with during

my PhD Journey and for me represents a unique group of persons who engender within me and reflective of my cultural traditions, the feelings of wholism. I have found places in nursing where I feel I have been able to flourish, none have been as inclusive nor have provided the human-to-human connection that I found through my experiences in being a member of SICoP at Edinburgh University. SiCOP is unique to the PhD student experience at this University. I wonder if this experience is related to us having a clear understanding of who we are as individuals and a strong sense of our collective personhood – that is the shared journey of research. During my thirty-six years of nursing, including my training, I have experienced and would argue that nursing as a community does not value having the time to know self or to understand our personhood collectively. During my experiences as a paediatric nurse, nurse manager, and nurse academic, I failed to see the relevance or value of collective personhood. This journey has opened my eyes. I did not start my career as a nurse because I loved nursing, in fact, I fell into the profession, however, over time, I have come to love being a nurse and am proud to say I am a nurse. It saddens me to see, hear and experience a profession I love, to be lost and not understand its own philosophical underpinnings. Drawing on Aboriginal culture and reflecting on my heritage, I would argue that if we as nurses, collectively took time to understand our nursing ontology (our way of Being) and nursing epistemology (our way of Knowing) we would have a greater sense of wellbeing as a profession and thus would-be inspirations to our profession. Wellbeing from this sense would embrace students and clinical supervisors knowing self to enable belonging, respect difference and individual personhood would be encouraged and respected. A wholism approach to personhood supports and accepts individual differences as an outcome of a shared collective understanding that in turn enables wellbeing (Grieves 2009). As a key discovery of my PhD research, this I believe is profound for the future of nursing and an area worthy of future dedicated person-centred research.

Sadly, I believe that students have been affected for some time by the lack of understanding of nursing personhood. I posed the argument in Chapter 4 that students from a behaviourist belonging perspective will fit into the culture, good, bad or indifferent (Levett-Jones and Lathlean 2009). Nurses foster the need to fit in through

their lack of understanding of the communal personhood of nursing and they revert to wanting students to look like them as this is all they know. This has been demonstrated in the information collection of this PhD research discoveries in Chapter 9, where I share in my field notes that students reported that they could identify the nurse they wanted to be and the ones they did not wish to emulate. They believed the role modelling they witnessed from the nurse they wanted to be, helped them to understand how to be the nurse they saw themselves to be in the future. They also indicated that they realised that in the reality of practice, they did not always react and respond as they thought they had predicted they would, for example, when exploring scenarios that emotionally challenged them in the Knowing phase of their education. I believe the information we collected during the PhD journey supported these ideas and shows how relevant power is alongside the complexity of relationships in the practice arena.

Clinical supervisors acknowledged they were role models for the students they were working with. They identified that they needed to accept and encourage their difference and that in reality, this was difficult to achieve. Marylou in her transcript (round one, part one) stated: “I think we are the role models, but we don't want them to copy us. We want them to have their own individual personality”. This insight shared by Marylou demonstrated that supervisors are open to accept and enable differences plus demonstrated a unique level of self-awareness.

Maya Angelou (Angelou and Elliott 1987) in a conversation argues that belonging from a freedom perspective is hard but rewarding. She states that you are only free (to be your true self) when you belong to no place, nothing, that you can only belong to yourself. Considering this definition, if nursing clarified our ontology and epistemology, I believe we would enable nurses of the future to be proactive in leading culture change through knowing self to enable belonging and respecting personhood. This fourth key discovery, along my PhD journey was that knowing self to enable belonging has the power to bring about change to the nursing profession that will enable individuals to be seen, heard and respected.

Epistemological Key Discoveries

The fifth key discovery along my PhD journey was that person-centred transformational learning in practice enables persons to support each other to create new learning perspectives and achieve a sense of human flourishing. The creation of the model for person-centred learning in practice (see Image 12-5 below) was developed from a practice perspective and adds to what is known about transformational learning in a classroom setting and addresses the limited knowledge about transformational learning in the context of practice or a non-classroom setting. As this PhD research has married the concept of transformational learning with person-centredness, a key finding is that person-centred learning has a transformational element inherent within it. I believe that by having both person-centred and transformational in the description of learning in practice acknowledged the philosophical underpinnings of the Person-centred Practice Framework (McCormack and McCance 2017) and created new knowledge by combining Mezirow's (1978) sentinel work on transformational learning. The image below (see Image 12-5) represents the part of the painting of my PhD journey that signifies the recombination of philosophies and theories used to create the underpinning theoretical framework for this PhD research.

Image 12-5 Epistemology on the PhD Journey - © Maria Mackay 2020

The framework in the image (see Image 12-5) depicts the process and influences that are required to enable person-centred transformational learning in the context of practice, the key context for this research. This framework was endorsed by the student and clinical supervisor co-researchers who participated in this research. The framework challenges the current approach to preparation for practice at UOW and how learning is facilitated in the reality of practice. O'Donnell et al. (2020) in their meta-synthesis of person-centredness in nursing curricula identified four themes that demonstrate nursing education is ready to embrace a move towards including person-centredness in pre-registration curricula (Dickson et al. 2020). The first theme was moving beyond mediocracy, where they argue that academic staff are frustrated with the traditional approaches to curriculum design and implementation and that there is a readiness for person-centredness to be introduced, along with a more creative approach to how curricula is designed. The theoretical model (see Image 12-6 below) developed as part of this PhD research aligns with this finding of moving beyond mediocracy, as it questions how we prepare and support students in practice and in Doing that promotes learning through discomfort (O'Donnell et al. 2020). My experience is that learning through discomfort and being enabled to problem solve requires academic and clinical nurses to be courageous and to have the foresight to enact what is right, which is not always easy. The issue of having the courage to resist contemporary approaches to curricula and to develop and implement person-centred curricula is an issue for the nursing profession moving forward. Currently, we keep doing what was always done, that is focussing on developing technically focussed curriculum. If we dared to have the courage to implement a curriculum that challenged students and academic staff to connect to their emotions, I propose that we may see different outcomes. I believe this is the key to developing nurses who have the courage and emotional intelligence to influence change.

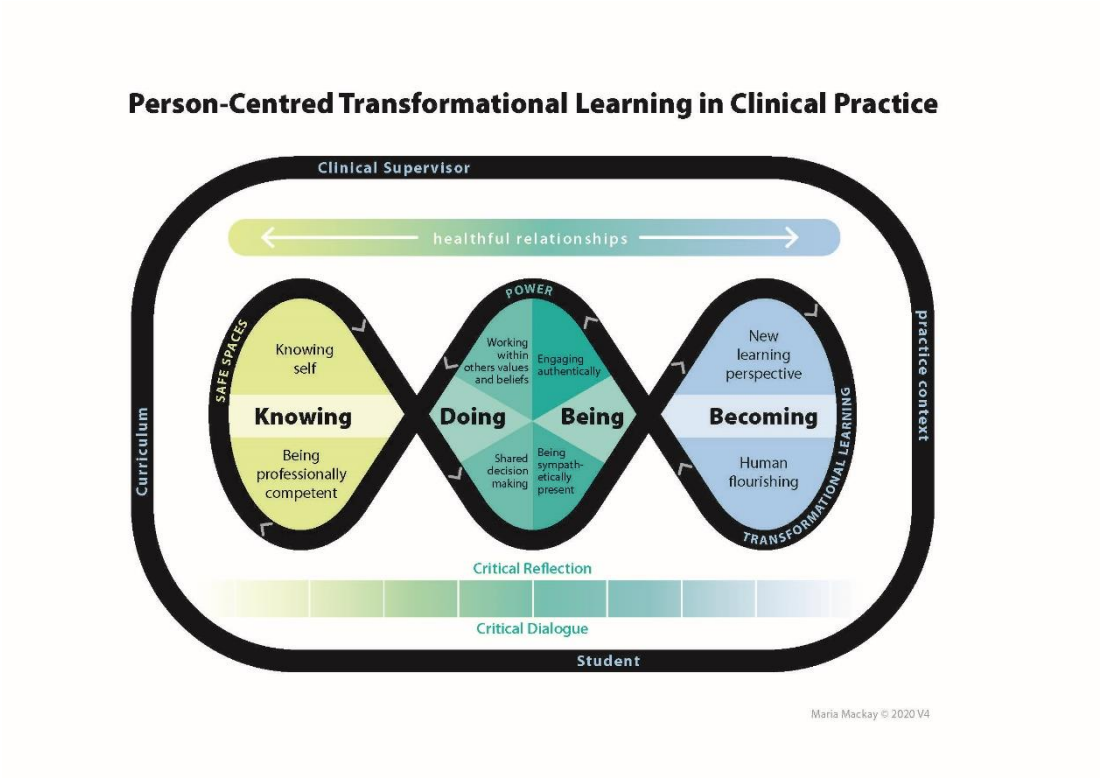


Image 12-6 Person-centred Transformational Learning in Clinical Practice Model V4 (2020)

The sixth key discovery from this PhD research was that being sympathetically present in the context of facilitating learning in practice is underpinned by active listening and companioning. In Chapter 10, I was challenged by the clinical supervisor co-researchers to consider the difference between empathy and being sympathetically present. This created a disorientating dilemma for me, and I used critical dialogue and critical reflection to transform my learning perspective on being sympathetically present. As discussed by McCormack and McCance (2010), the word empathy and sympathy are embedded in nursing education and from a simplistic perspective, nurses are taught to believe that sympathy is not supportive of others and empathy is a connection with others. In dialogue with colleagues and other nurses, I believe the uncomfortable rhetoric around being sympathetically present is a confusion between the difference that is inherent in the terms of sympathy and being sympathetically present. Once we re-read the definition of being sympathetically present, the clinical supervisor co-researchers were comfortable to keep the term being sympathetically present, even though their initial reaction was it should change to being empathetically present.

Sympathetic presence was originally aligned to person-centred practice by McCormack (2002, p.204) within the Framework of Person-centredness as Authentic Consciousness. The initial Person-Centred Nursing Framework (McCormack and McCance 2010) included the phrase having a sympathetic presence and this was further developed in the Person-centred Practice Framework (McCormack and McCance 2017) to being sympathetically present. Being sympathetically present is defined by McCormack and McCance (2017, p.57) as: "An engagement that recognises the uniqueness and value of the individual, by appropriately responding to cues that maximise coping resources through the important agendas in their life." The 2017 iteration of being sympathetically present highlighted by the change, from having to being, associated the concept of being present with the persons we care for with Benner's (1984) ideas on the art of nursing and presencing. These ideas align well with my PhD research, as from a person-centred transformational learning perspective, I have associated the Doing in practice with the actions of critical dialogue and reflection and the being in practice with active listening and companioning. Transposing the term being sympathetically present from the context of caring for persons in practice to facilitating learning between students and clinical supervisors in practice, I have found from undertaking this PhD research, that being with through authentic presence and being sympathetically present is a powerful process that enables the learner to consider others whilst still maintaining their self-awareness of their own learning.

In Chapter 10, from undertaking this PhD research, I have found that crafting of healthful relationships enables being sympathetically present through the art of active listening and companioning. This is supported by McCormack and McCance (2017) where they describe being present as both an active and passive exchange between persons where visibility and ability to demonstrate exemplary interpersonal skills is the linchpin to the other person-centred processes. Rogers and Farson (1979) consider active listening as an important way to bring about changes in people. They explore three activities that are associated with active listening: listening for meaning, responding to feelings and noting all the cues. Merging active listening with the art of companioning, Popov (2004), describes companioning as "one of the greatest gifts we have to give is our presence – our compassionate, attentive listening. It is a form of

sacred curiosity. By being deeply present and listening with both compassion and detachment we help others to empty their cup." She further ruminates that companioning as a way of being with others enables them to bring to the surface their teachable moments and where the role of the listening is not to respond, or problem-solve rather just to be with the other. Companioning is always completed with an acknowledgement where the listener acknowledges the vulnerability of the story and the courage of others in being open and sharing (Popov 2004). Therefore, engaging authentically and being sympathetically present have been applied to the context of nursing education within this PhD research within the art of being in practice when considering person-centred transformational learning. O'Donnell et al. (2020) identify that the curricula suitcase creates a challenge to include person-centredness into an already overcrowded curriculum and I would argue that preparation that enables the transformation of learning perspectives and human flourishing in practice would be something that many traditional academics would not value as important to include.

Methodological Key Discoveries

Moving along the road to methodology, developing person-centred approaches to research was for me as challenging as the vulnerability of my ontological journey. As I reached this part of the journey, I was required to create a person-centred methodology that would enable the principles of person-centred research. I was again required to look inside myself and unlock creativity. I started by exploring the principles that are important for person-centred researchers to consider. Jacobs et al. (2017) describe the main principle for application as connectivity, along with three related principles: attentiveness and dialogue, empowerment and participation and critical reflexivity. The main principle of connectivity is significant, in that as person-centred researchers we do not research about others, instead we research with others. The image (see Image 12-7) shows the section of the painting (My Research Journey) that represents my methodology part of the road. It highlights the overarching principles of the person-centred methodology developed for this PhD research that enabled me to create my methodological principles.

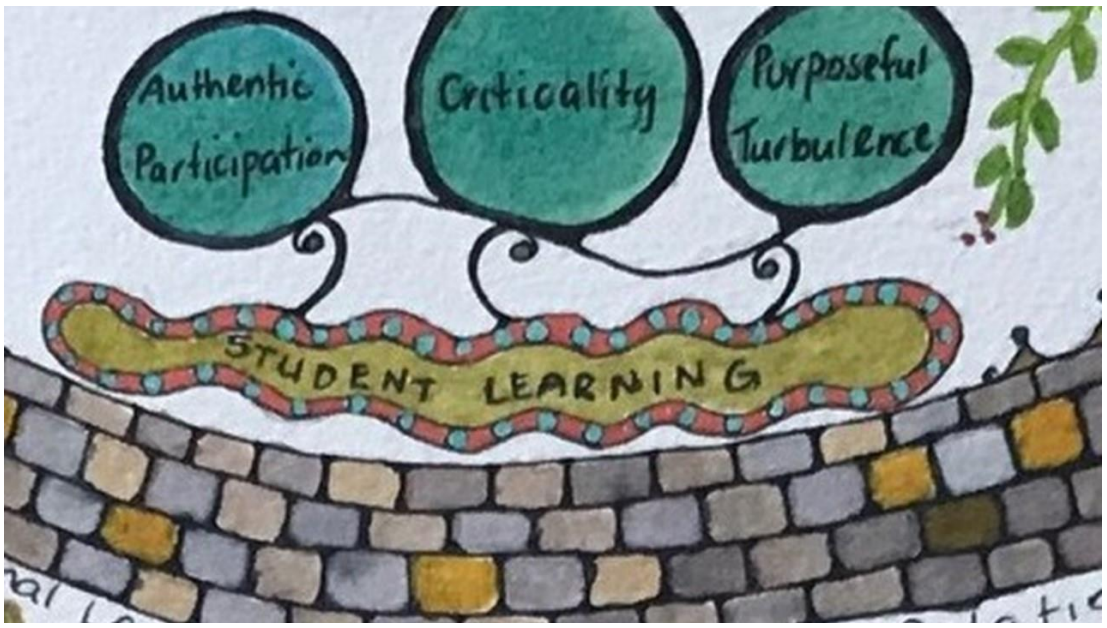


Image 12-7 Methodology on the PhD Journey - © Maria Mackay 2020

At this point, I gained a renewed understanding and passion for the use of the Dadirri poem (Ungunmerr 1988) and utilised parts of the poem to describe the principles within the methodological framework (see Image 12-8 below). This enabled me to contemplate how I would ensure rigour and reflexivity were embedded in this research with students and clinical supervisors. The development of this methodological framework for me was transformational in that I gained a deeper appreciation of Dadirri poem (Ungunmerr 1988) and embodied the words and meaning of Dadirri. Inner deep listening and quiet still awareness are integral to the elements of the methodology in the framework above, as it is through the contemplative way of Dadirri, where healthful relationships between myself, the participant and co-researchers were undertaken as research partners.

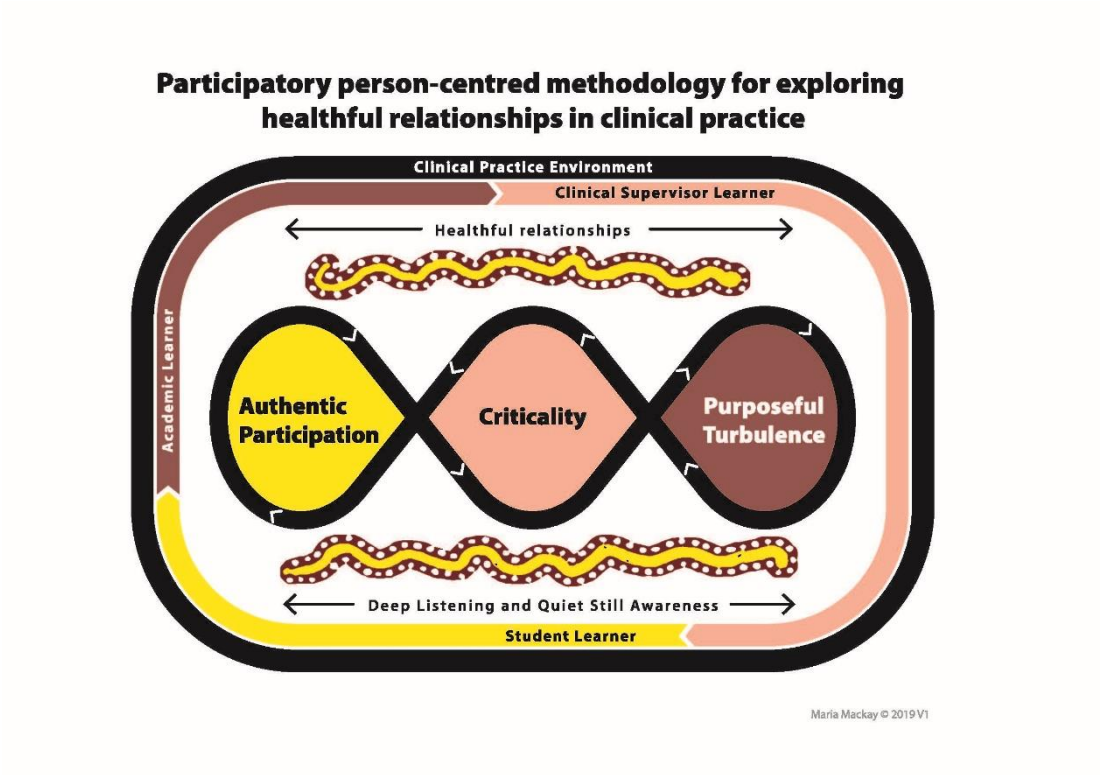


Image 12-8 Participatory Person-Centred Methodology for Exploring Healthful Relationships in Clinical Practice (2018)

The seventh key discovery was that the practice of Dadirri (inner deep listening and quiet still awareness) facilitates the transition of the turbulence of person-centred research in the reality of practice into purposeful turbulence. I described purposeful turbulence in Chapter 7 using the words of Dadirri:

> We don't worry. We know that in time and in the spirit of Dadirri (that deep listening and quiet stillness) the way will be made clear. We are like the tree standing in the middle of a bushfire sweeping through the timber. The leaves are scorched and the tough bark is scarred and burnt, but inside the tree the sap is still flowing and under the ground the roots are still strong. Like that tree we have endured the flames and we still have the power to be re-born. (Ungunmerr 1988).

I had no idea when I wrote this that I would personally experience a bushfire in my home and see for myself the turbulence that bushfires are in themselves and the associated turbulence that they create within the community. I live on a 16-acre property and the re-birth or purposefulness of the fire that has been evident in our gum trees, plus the experience of seeing the regrowth of the trees has been beautiful and

inspiring. Transposing this to person-centred research, the practice of contemplation enables all of us (participants, co-researchers and myself) to have the power to be reborn and flourish in our understanding of ourselves as person-centred researchers (Ungunmerr 1988). The Sturt Desert Pea flower's analogy, where only a few drops of rain is required for the seed that has laid dormant for several years to blossom, is relevant here. Moving from turbulence to purposeful turbulence only requires a sprinkle of connection. This purposefulness also moves through to the synthesis and meta-synthesis process to reveal the discoveries within this PhD research. In the words of Dadirri (Ungunmerr 1988), "I believe the spirit of Dadirri is that what we have to offer will blossom and grow, not just within ourselves, but within our whole nation. For me, this represents purposeful turbulence as individual growth and growth in our contributions to the knowledge developed from this PhD research. In conclusion, by undertaking this PhD research, I now believe that purposeful turbulence is a fundamental person-centred research principle in the reality of the practice context. I believe that the principle of purposeful turbulence has an impact on clarifying the messiness and muddiness of being a person-centred researcher as I discussed in Chapter 11.

Methods Key Discoveries

The eighth key discovery was that the combination of emoji and Dadirri as information collection methods brought richness and depth to the process of research information collection. Emerging from a literature review (see Appendix G) that was undertaken as part of this PhD research, we identified that there is little known on the use of emoji as a research information collection tool and there is silence in the evidence for their use in health education research. The concept of emoji as a research information collection tool was instigated from co-design workshops held in the planning stage of this PhD research with participants and outlined in Chapter 8. Kemmis et al. (2013), propose that to be authentically participatory in research, collaboration with participants and co-researchers should start at the planning phase and continue throughout the research process. Workshops were held as discussed in Chapter 8 with potential participants before the commencement of information collection to ensure that the development of methods was collaborative and inclusive of students and

clinical supervisors' perspectives. The use of emoji as an information collection tool was embedded in this PhD research and the image (see Image 12-9) below represents this on my PhD journey painting.

Image 12-9 Methods on my PhD Journey - © Maria Mackay 2020

The ancient wisdom of learning about self, the environment and our spiritual wellbeing though deep listening has a sacred place in many indigenous cultures. including Australian and Asian contemplative practice (Brunner 2006; Ungunmerr 1988). Oliveros (2005), was influenced by Buddhist meditation and is thought to have coined the term deep listening from a western perspective. She considers deep listening to blend the mind and heart and argues that the contemplation associated with deep listening is both passive in having a relaxed open mind and active in having a receptive mind. From a music therapy perspective (Ungunmerr 1988), Pavlicevic and Impey (2013) expanded on the concepts of Oliveros (2005) and align deep listening with creating therapeutic relationships. This form of deep listening is considered to enable connections to memories, cultural contexts and embodied knowing (Pavlicevic and Impey 2013). The Australian Indigenous practice of Dadirri is inner deep listening and quiet still awareness (Ungunmerr 1988). Contemplation using the ancient wisdom of Dadirri enables the melding of mind and heart and connections to our embodied knowing (Ungunmerr 1988). In the words from the Dadirri poem “We do not worry.

We know that in time and in the spirit of Dadirri (inner deep listening and quiet stillness) the way will be made clear" (Ungunmerr 1988).

This PhD research discovered that using emoji in conjunction with the practice of Dadirri after each day of their clinical placement, learners were able to connect to their emotions, open their hearts and minds, take time and reflect on the human-to-human connections they encountered that day. Both the students and clinical supervisors reported that this daily practice supported them to reflect on their practice and consider how they could authentically show up the next day and improve their relationships with others.

Synthesis and Meta-synthesis Key Discoveries

The image below (see Image 12-10) represents the part of the PhD painting where reflection was used for synthesis and meta-synthesis where the process of contemplation (Ungunmerr 1988) was embedded within how the synthesis and meta-synthesis of information was undertaken. Dadirri or inner deep listening and quiet still awareness is something that has informed how the key discoveries emerged along this journey as well as more specifically in the process of synthesis and meta-synthesis.

Image 12-10 Synthesis and Meta-synthesis on my PhD Journey - © Maria Mackay 2020

The ninth key discovery was that the emotional preparation of students and clinical supervisors is required prior to a practice experience to enable the crafting of healthful relationships that foster person-centred transformation learning in practice. I have always believed that there was a need to prepare students in the art and science of nursing and prepare clinical supervisors to be able to undertake their important role of supervising students in practice. It was not until I undertook this PhD research that I discovered that although we need to prepare the students and clinical supervisors technically to safely undertake their roles in clinical practice, we also need to consider the emotional preparation of both these groups and consider how we do this, so both are prepared to craft healthful relationship between themselves and with others.

O'Donnell et al. (2020) in their meta-synthesis found that there was a need to move beyond mediocrity and that the time is right for challenging traditional approaches to learning and teaching as academic staff are ready to embrace person-centredness. This research supports the need for innovative approaches to curricula and has unveiled some of the challenges of adopting person-centred curricula. The discoveries of this PhD research demonstrate the lack of knowledge (or preparation) amongst nursing staff in person-centredness and thus, students were challenged with not seeing role modelling of person-centred practices (Hardiman and Dewing 2019), in the reality of practice. Both students and clinical supervisors reported that knowing self to enable belonging assisted them to consider and reflect on their reactions and responses to the disorientating dilemmas they faced in practice (Mezirow 2009). They were able to identify times where they thought in a classroom setting that they would respond or react to a situation rationally however, in the reality of practice, they reacted against their values (Brown 2010). Students and clinical supervisors have recommended that to move forward, that the use of emoji and Dadirri would enable their connection to emotions and help them to reflect on their practice. This is an example from this PhD research of a creative and innovative approach to learning and teaching.

The Knowing phase of the person-centred transformational model for learning in clinical practice has the person-centred pre-requisites of knowing self and being professionally competent (McCormack and McCance 2017). The focus of being

professionally competent is inclusive of the art and science of nursing (McCormack and McCance 2017). Current curricula in the Australian context are burdened with the technical preparation for practice. This PhD research has highlighted the need for the emotional preparation of both students and clinical supervisors. The consideration of developing learning and teaching resources needs to ensure both groups have input into the design of the learning and teaching resources and that there is equivalence in the preparation for crafting healthful relationships amongst students and clinical supervisors. The students in this research's exploratory phase highlighted that they were disadvantaged as they did not receive the same preparation to engage with and create healthful relationships as the clinical supervisors. The exploratory research project – Enabling the voice of students in creating healthful relationships resulted in the development of the Student Led Conversation Form that is now used by all students in the university (UOW) this PhD research was undertaken, to enable students to share their values, expectations, and fears with their clinical supervisors. One student who participated as a co-researcher reported that she was a returning student and had experienced the previous curriculum, and she felt the revised curriculum with emotional challenges in the Knowing phase in her preparation for practice emotionally prepared her much more than the older curriculum.

Overall, the emotional preparation for students and their clinical supervisors prior to a placement experience has a short-term impact, as well as a longer impact where it enhances their ability in knowing self to enable belonging. Influencing nurses of the future to understand their values and to have high-level emotional literacy skills enables them to craft healthful relationships that are true to their values. Currently, there is rhetoric that refers to a theory-practice gap (Salifu et al. 2018), though these are not words I would use, rather I would suggest that we as a nursing profession focus too greatly on the technical preparation of students for practice at the sacrifice of their emotional skill development. Gallagher (2004) in a discussion paper argues the word gap gives a negative connotation to the term theory-practice gap and the use of the word. An alternate perspective is that the research and theories that inform nursing education need to sit at a more advanced level than the reality of practice, informing the future workforce, and enabling cultural change (Kyrkjebø and Hage 2004).

As a result of undertaking this PhD research, I, therefore, advocate that if we enable students to feel empowered, be connected to their emotions and understand how they react and respond to challenges, we have the potential to change nurses' perceptions of belonging to fit, into that of knowing self to enable belonging. I would argue this would provide nurses of the future to be professionally competent to influence cultural change. I am not suggesting that there should not be a focus on technical competence, I accept this is important, rather I am asserting that we need to reconsider the balance between the art and science of nursing in developing person-centred transformational curricula that prepares our future nurses for the turbulence in the reality of practice. A risk here is the high regard universities have for student satisfaction survey results. I would argue that developing curricula that challenges students to the point of discomfort can lead to some initial level of frustration. In my experience, this frustration is greatest in year one of the program and students over time come to see the value of this form of learning.

The tenth and final key discovery is the need for a variety of voices to be present in the development of person-centred transformational curricula to ensure students and academic staff are adequately prepared to facilitate learning in the reality of practice. McCormack and Dewing (2019, p.1) have argued that although there has been a concerted effort by many universities to integrate person-centredness into curricula it remains "largely sporadic, inconsistent in approach and operating at different degrees of explicitness in terms of the representations of person-centred concepts, theories and principles." My experience as the Director of Clinical Learning in developing and designing person-centred curriculum would be to support that a school of nursing should move to a culture of being open to learn, unlearn and relearn. The concept of being open to learn, unlearn is explored in Chapter 10 as part of the model for Crafting Healthful Relationships. Coming to recognise what should and should not sit within a curriculum takes courage and is an interactive process that will be ever-evolving.

O'Donnell et al. (2017), in their chapter, provide an example of person-centred practice learning structure and support from the United Kingdom (UK) perspective. This model has the representation of many voices and is based in the UK model of student support

with mentors, link lecturers and services users' voices being present with academic staff. This PhD research supports the need for voices to be authentically listened to and heard. In the Australian context, the ANMAC (2019, 8) Standards for accreditation, Standard 2.3 requires:

> The education provider undertakes consultation into the design and ongoing management of the program from external representatives of the nursing profession, including Aboriginal and/or Torres Strait Islander peoples, consumers, students, carers and other relevant stakeholders.

This PhD research found that students in year 1 and clinical supervisors who are employed as casual academic staff provided great insight into the development of learning and teaching resources and that in the future, the involvement of students and casual academic staff more broadly should be considered. The current approach to the involvement of students and academic staff is inconsistent, at times tokenistic and needs to be challenged adopting an approach of co-creation of curricula and learning and teaching resources more holistically.

The final voice that was dominant in this PhD was that of Maya Angelou and the influence she has had on our collective understanding of belonging. Maya Angelou (Angelou and Elliott 1987, p.22) in her own words describes belonging as: - "*you are only free when you realize you belong no place – you belong every place – no place at all. The price is high. The reward is great*." Maya Angelou has been reported as being one of the most famous and influential voices in America however she is not an academic voice. She is also described as a radical feminist American Poet (Permatasari 2016). For example, If I had chosen to use only peer-reviewed articles on belonging, I would not have considered belonging from a freedom perspective and the sense of belonging we have explored would be vastly different and I would suggest continue to support belonging as fitting in from a behaviouralist perspective. I raise this because curricula need a variety of voices that have academic rigour as well as voices that enable us to bring other perspectives that decolonise the lens we place on nursing. I have attempted to bring together a western academic understanding of research and practice-based curriculum with Indigenous ancient wisdom in this PhD research. Ancient wisdom exists in many aspects of the Person-centred Practice Framework,

with one example being the connection to our embodied knowing by clarifying values and beliefs. The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) (of which I am a member) has published The Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework (2017). This is a tool to enable the consideration of Aboriginal and Torres Strait Islander perspectives of health and cultural safety along with how to engage with and support our Aboriginal and Torres Strait Islander students. CATSINaM (2017, P.11) state:

> In regards to Aboriginal and Torres Strait Islander health, cultural safety provides a decolonising model of practice based on dialogue, communication, power-sharing and negotiation, and the acknowledgement of white privilege. These actions are a means to challenge racism at personal and institutional levels, and to establish trust in health care encounters.

This PhD research though the emerging significance of the Dadirri poem (Ungunmerr 1988) and the inclusion of Maya Angelou's (Angelou and Elliott 1987) definition of belonging, has demonstrated that the inclusion of voices that share ancient wisdom has a powerful impact on how we see and understand nursing practice. Future development of nursing curricula internationally needs to consider decolonising the rhetoric of healthcare and significantly highlight white privilege in the history of healthcare and the impact this has had on the health outcomes globally for our Indigenous peoples.

Summary of Key Discoveries

I have highlighted ten key discoveries that emerge from my PhD journey and are represented in the image (see Image 12-11) below. Each of these are unique in themselves and all then interrelate to bring me to the end of this journey.

Image 12-11 My PhD Journey - © Maria Mackay 2020

These key discoveries are:

1. Allowing ourselves to feel and express our vulnerability enables us to make a more authentic human-to-human connection.
2. Connecting to my vulnerability as a person-centred researcher has enabled me to connect to Dadirri and allow myself to meld the values of my culture to Dadirri as a conduit to enabling an openness to learn and unlearn and relearn.
3. The tension that exists for nurses in our profession due to the lack of understanding of our collective nursing personhood.
4. Knowing self to enable belonging has the power to bring change to the nursing profession that will enable individuals to be seen, heard and respected.
5. Person-centred transformational learning in practice is enabled within a process of persons supporting each other to create new learning perspective and achieve a sense of human flourishing.
6. Being sympathetically present in the context of facilitating learning in practice is underpinned by active listening and companioning.
7. The practice of Dadirri (inner deep listening and quiet still awareness) facilitates the transition of the turbulence of person-centred research in the reality of practice into purposeful turbulence.

8. The combination of emoji and Dadirri as information collection methods brought richness and depth to the process of research information collection.
9. The emotional preparation of students and clinical supervisors is required prior to a practice experience to enable the crafting of healthful relationships that foster person-centred transformational learning in practice.
10. The need for a variety of voices to be present in the development of person-centred transformational curricula.

Recommendations

The recommendations that I want to emerge from this PhD research are:

1. That the guidelines for the facilitation of learning between students and their clinical supervisors in practice should be considered by other universities that educate nurses as a model to support how to facilitate person-centred transformational learning.
2. That the Healthful Relationships framework should be seen as a toolfor enabling the crafting of healthful relationships that encourage student and clinical supervisors to know self to enable belonging and respect personhood in practice.
3. That the theoretical framework for 'Person-centred Transformational Learning in Clinical Practice' should inform how universities consider the development of holistic approaches to person-centred curriculum development and implementation from a practice context.
4. The inclusion of emotional literacy skills should be adopted within pre-registration nursing curricula for students and clinical supervisors to prepare them for the reality of practice.
5. That the inclusion of co-design of the curriculum challenges the existing approach to advisory committees and adopts an authentic inclusion of a diverse range of representation, including those who will have a voice in the decolonisation of historical white privilege.
6. Nursing and Midwifery leaders should consider how collectively the nursing profession could develop an understanding of their collective personhood and

enable a person-centred approach to accepting difference of students and clinical supervisors within the constraints of the NMBA (2016) Registered Nurse Standards for Practice

7. That consideration be given to the use of Indigenous methodology within nursing research where relevant.

Future Research

I believe the focus for future research should be:

- The exploration of the experience of students, new graduates and health care services regarding the impact of their perception on their ability to influence person-centred learning cultures in the reality of practice.
- Research into the impact of embedding emotional skills curriculum has on the awareness of knowing self to enable belonging and respecting personhood for students and new graduate nurses in practice.
- The exploration of the model of healthful relationships in other contexts and across multi-disciplinary professions.
- The evaluation of the Model for Person-centred Transformational Learning in Practice.
- Further exploration of the use of Dadirri and emoji as a research information collection process.
- Exploration of the perception of students who experience curriculum from a decolonisation perspective.

Limitations of the Research

Although this PhD research was undertaken with the consideration of an approach to rigour underpinned by reflexivity, there were inherent limitations in the PhD research's philosophical and methodological underpinnings. This research is based within the critical paradigm which accepts multiple realities therefore, the transferability of discoveries made within it may inform practice in other contexts. However, it is accepted this was not the PhD research's principal concern (McCormack et al. 2017, p.44). Another related limitation was that this PhD research was undertaken at one

university with a limited number of participants and co-researchers therefore the discoveries are relevant to the context the research was conducted within.

The messiness and muddiness of the person-centred research and the process of co-research created limitations in that the methods used were developed collaboratively and were original in the form of emoji and Dadirri. A final limitation was that the methods gathered information from persons in the reality of practice and as co-researchers, the synthesis of this information was subject to issues related to the persons' interpretation and their experiences (Polit and Beck 2018).

Research Impact

Along my PhD journey, there has been one guideline, a Student-Led Conversation Form and three publications completed. The completed outputs have all been explored in more detail in Chapter 5.

The Guideline for Facilitating Learning between Students and Clinical Supervisors in Practice (see Appendix C) includes the Student-Led Conversation Form (see Appendix E) that was developed from the exploratory phase of this PhD research. This guideline has been implemented at the university where this PhD research was conducted in NSW Australia and will influence the practice placements of approximately 1800 students and 70 clinical supervisors per year, with subsequent interest from other universities in Australia to utilise this guideline. There is also interest from Canada and the guideline will be shared with the members of Person-centred Practice International Collaborative of Practice (www.pcpr.org). The Student-Led Conversation Form is currently included in the assessment in practice documents for all students at the university where this PhD research was undertaken. That equates to approximately 1500 students per clinical placement period, each of these students will have 2 clinical placement per academic year.

As noted in Chapter 5, I was the lead author and made significant contrition to each of the publications below. Publications that have come from this PhD research are:

1. Making sense of critical participatory action research. Reflections on The Action Research Planner: Doing Critical Participatory Action Research is

published in the International Practice Development Journal.

The paper was published in the International Practice Development Journal, 16 November 2016. It is attached to this thesis as Appendix F.

MACKAY, M. 2016 Making sense of critical participatory action research. Reflections on The Action Research Planner: Doing Critical Participatory Action Research. *International Practice Development Journal*, vol. 6, no. 2, pp.1-3. [Accessed 4 November 2020]. Available from: https://doi.org/10.19043/ipdj.62.013

2. How do we consider the impact of clinical supervisor education? A participatory literature review is published in the International Practice Development Journal

   The published article is included as Appendix B:

   MACKAY, M., RILEY, K. and DEWING, J. 2019. How do we consider the impact of clinical supervisor education? A participatory literature review. *International Practice Development Journal*. vol. 9, no. 1, pp.1-16 [Accessed 4 November 2020]. Available from: https://doi.org/10.19043/ipdj.91.007

3. 'Enabling the voice of nursing students in designing an educational resource for their preparation to participate in the reality of clinical practice' has been accepted for peer review with the International Practice Development Journal (see Appendix D).

4. How do emoji facilitate learners within the context of healthcare education research? A scoping review has been accepted for peer review in Contemporary Nurse. been accepted for peer review in The Journal of Professional Nursing (see Appendix G).

I have a plan for this PhD research to be shared broadly. Currently, in Australia, international travel that is not deemed as essential (such as for conference

presentations) is not permitted until 2023 due to the COVID-19 pandemic. I will endeavour to disseminate the key discoveries in conferences in Australia and New Zealand (with the establishment of an agreed travel bubble) and virtually for other countries. I have outlined my Impact Plan in an attached Appendix (see Appendix S).

My Learning Outcomes

I have discovered as much about myself as a person-centred researcher and the process of person-centred research as I have discovered about healthful relationships and their influence on person-centred transformational learning. My personal key learning has been the impact the practice of Dadirri has on me as a person and a researcher, it is what enables me to flourish. My key learning from this PhD research is that healthful relationships, as we have co-defined them, underpin person-centred transformational learning and this is something I now see as a new learning perspective.

My Future Journeys as a Person-centred Researcher

My future will accommodate a plan where I undertake further research on healthful relationships and their application to other contexts and more broadly to other parts of nursing and allied health staff. The concept of healthful relationships is new that requires further exploration and I believe the model developed within this PhD research has applicability more broadly. I hope to join the Person-centred Practice, International Community of Practice (PcP ICOP) and contribute to person-centred research with an emphasis on developing person-centred curricula. I also have a strong interest in developing further the Indigenous methodological approaches to research, particularly using the concept of Dadirri in other applications. Moving forward, I am excited to continue to explore the merging of Indigenous ancient wisdom with the newer eastern modern technology of emoji as a research method for unlocking emotions and exploring the impact of feeling and emotions in the development of ourselves as person-centred nurses and researchers. This also connects to my interest in decolonising curricula and undertaking future research on how to bring first peoples voices into curriculum design. Finally, I aim to undertake co-design research with students and develop approaches that enable collaborative development of learning and teaching resources.

Chapter Summary

In this chapter, I have shared the key discoveries from my PhD journey, the associated recommendations, the research impact and its limitations. I then moved to consider my personal learning and future research journey. I have shared the impact this research has had for the university where this research was based, a summary of the publications that have been submitted to date and the future plan for the impact of this PhD research. The new knowledge generated from this PhD research has contributed to person-centred theory, methods and understanding of how healthful relationships influence person-centred transformational learning. Original contributions from the key discoveries included the development of the theoretical framework titled the Person-centred Transformational Learning in Clinical Practice and a person-centred approach to methods for information collection using Dadirri and emoji. Other original contributions added to what is known about the definition and understanding of healthful relationships between students and clinical supervisors in the context of practice. Finally, a significant creative original contribution has been the understanding of transformational learning in the practice context.

As I reach the end of this PhD journey, my hope is that this thesis provides new knowledge for the development of person-centred learning curricula that prepares students and clinical supervisors to flourish in the reality of practice. My personal journey as shown in the image (see Image 12-12) below demonstrates the complexity, learning and joy I have experienced in my growth as a person-centred researcher. I look forward to taking the key discoveries forward in the next chapter of my research journey.

Image 12-12 My PhD Journey - © Maria Mackay 2020

References

ALZHEIMER EUROPE., 2017. *Personhood* [Online]. [Accessed 16 January 2013]. Available from: http://www.alzheimer-europe.org/Ethics/Definitions-and-approaches/Other-ethical-principles/Personhood

ANDREWS, M., 2019. *Journey into dreamtime*. Victoria: Ultimate World Publishing.

ANGELOU, M. and ELLIOT, J.M., 1989. *Conversations with Maya Angelou.* London: Virago.

ARCHER, M. S., 1988. *Critical realism: Essential readings*. London: Routledge.

ARCHIBALD, M.M., AMBAGTSHEER, R.C., CASEY, M.G. and LAWLESS, M., 2019. Using Zoom Videoconferencing for qualitative data collection: Perceptions and experiences of researchers and participants. *International Journal of Qualitative Methods* [Online]. [Accessed 21 November 2020]. Available from: https://doi.org/10.1177%2F1609406919874596

ARKSEY, H., & O'MALLEY, L., 2005. Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology: Theory & Practice*. vol. 8, no. 1. pp. 19–32.

ATKINSON, J., 2020. *Words of wisdom on cultural healing* [Online]. [Accessed 20 November 2019]. Available from: http://leadpda.org.au/documents/leadpda_rap_dadirri.pdf

AUSTRALIAN HUMAN RIGHTS COMMISSION., 2015. *Tracking the history timeline: The stolen generations* [Online]. [Accessed 24 October 2015]. Available from: https://humanrights.gov.au/our-work/education/track-history-timeline-stolen-generations

AUSTRALIAN NURSING AND MIDWIFERY ACCREDITATION COUNCIL (ANMAC)., 2019. *Registered Nurse Accreditation Standards 2019* [Online]. Canberra: ANMAC [Accessed 24 October 2019]. Available from https://www.anmac.org.au/sites/default/files/documents/registerednurseaccreditationstandards2019.pdf

BARTON, A.J., ARMSTRONG, G., PREHEIM, G., GELMON, S.B. and ANDRUS, L.C., 2009. A national Delphi to determine developmental progression of quality and safety competencies in nursing education. *Nursing Outlook.* vol. 57, no. 6, pp. 313-322.

BAI, Q., DAN, Q., MU, Z. and YANG, M., 2019. A systematic review of emoji: Current research and future perspectives. *Frontiers in Psychology.* vol. 10, pp. 22-21 [Accessed 9 December 2019]. Available from: https://doi.org/10.3389/fpsyg.2019.02221

BAYNES, K., 2016. *Habermas.* Oxon: Routledge.

BENNER, P., 1984. *From novice to expert, excellence and power in clinical nursing practice*. CA: Addison-Wesley Publishing Company.

BERGOLD, J. and THOMAS, S., 2012. Participatory research methods: A methodological approach in motion. *Historical Social Research*. vol. 37, no. 1, pp. 191-222.

BHASKAR, R. and HARTWIG, M., 2010. *The formation of critical realism: A personal perspective.* New York: Routledge.

BHASKAR, R.A., 2008. *A realist theory of science.* 3rd ed. London: The Harvester Press.

BOOTH, A., PAPAIOANNOU, D. and SUTTON, A., 2012. Systematic approaches to a successful literature review. London: Sage.

BORROTT, N., DAY, G.E., LEVETT-JONES, T. and SEDGWICK, M., 2016. Nursing students' belongingness and workplace satisfaction: Quantitative findings of a mixed methods study. *Nurse Education Today*. vol. 45, pp. 29-34.

BRACKETT, M., 2019. *Permission to feel*. London: UK: Quercus Publishing.

BRADLEY, P., ROXBURGH, M. and LAUDER, W., 2012. *A follow up to new approaches to providing practice placements in the pre-registration nursing programmes: A comparison study of the year one pilot students and their year 2 experience The Final Report* [Online]. Scotland: University of Stirling. [Accessed 2 June 2017]. Available from https://www.stir.ac.uk/research/hub/publication/749794

BROOKFIELD, S., 1995. *Becoming a critically reflective teacher*. San Francisco: Josey-Bass Inc.

BROOKFIELD, S., D., 2010. *Radicalizing learning: Adult education for a just world.* San Francisco: Jossey-Bass Inc.

BOOTH, A., PAPAIOANNOU, D. and SUTTON, A., 2012. *Systematic approaches to a successful literature review.* London: Sage.

BROWN, B., 2010. *The gifts of imperfection: Let go of who you think you're supposed to be and embrace who you are.* Minn: Hazelden.

BROWN, B., 2012. *Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead.* New York: Gotham Books.

BROWN, B., 2017. *Braving the wilderness: the quest for true belonging and the courage to stand alone.* New York: Random House.

BROWN, B., 2018. *Dare to lead: Brave work. Tough conversations. Whole hearts*. London: Ebury Publishing.

BRUNNER, L., 2006. Deep listening: A composer's sound practice. *Notes*. March, vol. 62, no. 3, pp. 715-718. [Accessed 3 June 2019]. Available from: http://www.jstor.org/stable/4487631

BUCKLEY, C., 2017. Knowing me, knowing you: using creative methods to highlight challenges and discover identity and context in an action research study. *International Practice Development Journal*. vol. 7, no. 2, pp. 1-7. [Accessed 2 October 2019]. Available from: https://doi.org/10.19043/ipdj.72.011

CARPER, B., 1978. Fundamental patterns of knowing in nursing. *Advances in Nursing Science* [Online]. October, vol. 1, no. 1, pp. 13-24 [Accessed 6 October 2015]. Available from: http://samples.jbpub.com/9780763765705/65705_CH03_V1xx.pdf

CLARE, J., LONGSON, D., GLOVER, P., SCHUBERT, S. and HOFMEYER, A., 1996. From university student to registered nurse: the perennial enigma. *Contemporary Nurse*. vol. 5, no. 4, pp. 169-175.

COGHLAN, D. and BRANNICK, T., eds. 2014. *Doing action research in your own organisation*. 1ST ed. London: Sage.

COHEN, L., MANION, L. and MORRISON, K., 2018. *Research methods in education*. 8th ed. Abingdon: Routledge.

COLLIER, A., 1994. *Critical realism: An introduction to Roy Bhaskar's philosophy*. London: Verso.

COMMONWEALTH OF AUSTRALIA., 2013. *Commonwealth of Australia Constitution Act* [Online]. Canberra ACT: Commonwealth. [Accessed 20 June 2016]. Available from: https://www.legislation.gov.au/Details/C2013Q00005

CONGRESS OF ABORIGINAL AND TORRES STRAIT ISLANDER NURSES and MIDWIVES (CATSINaM), 2017. *The Nursing and Midwifery Aboriginal and Torres Strait Islander health curriculum framework* [Online]. ACT: CATSINaM [Accessed 2 February 2019]. Available from: https://www.catsinam.org.au/static/uploads/files/nursing-midwifery-health-curriculum-framework-final-version-1-0-wfffegyedblq.pdf

COOPER, S., CANT, R., WATERS, D., LUDERS, E., HENDERSON, A., WILLETTS, G., TOWER, M., REID-SEARL, K., RYAN, C. and HOOD, K. 2020. Measuring the quality of nursing clinical placements and the development of the Placement Evaluation Tool (PET) in a mixed methods co-design project. *BMC Nursing*. vol. 19, no. 1, pp. 1-10 [Accessed 25 November 2020]. Available from: http://doi: https://doi.org/10.1186/s12912-020-00491-1

COURTNEY-PRATT, H., FITZGERALD, M., FORD, K., MARSDEN, K. and MARLOW, A., 2012. Quality clinical placements for undergraduate nursing students: A cross-sectional survey of undergraduates and supervising nurses. *Journal of Advanced Nursing*. vol. 68, no. 6, pp. 1380-1390 [Accessed 2 February 2020]. Available from: http://doi:10.1111/j.1365-2648.2011.05851.x

CENTRE FOR REVIEWS AND DISSEMINATION (CRD), 2009. *Systematic reviews: CRD's guidance for undertaking reviews in health care* [Online]. York: York Publishing Services, Ltd. [Accessed 15 October 2018] Available from: https://www.york.ac.uk/media/crd/Systematic_Reviews.pdf

DANIEL B. K., 2018. Empirical verification of the "TACT" Framework for teaching rigour in qualitative research methodology. *Qualitative Research Journal*. vol. 18, no. 3, pp. 262-275.

DEWING, J., 2006. Wandering into the future: reconceptualizing wandering 'A natural and good thing'. *International Journal of Older People Nursing*. vol. 1, no. 4, pp. 239-249.

DEWING, J., 2010. Moments of movement: Active learning and practice development. *Nurse Education in Practice*. vol. 10, no. 1, pp. 22-26.

DEWING, J., 2019. On Being a Person. In: T. KITWOOD, and D. BROOKER, eds., *Dementia reconsidered: Revisited 20 years on.* London: Open University Press, pp. 17-23.

DEWING, J., 2020. Person-centred nursing framework. 17 October [Skype conversation].

DEWING, J., EIDE, T. and McCORMACK, B., 2017. Philosophical perspectives on person-centredness for healthcare research. In: B. McCORMACK, S., van DULMAN, H., EIDE, K., SKOVDAHL, and T., EIDE, eds. *Person-centred healthcare research.*1st ed. Chichester: Wiley Blackwell. pp. 19-29.

DEWING, J., McCORMACK, B. and TITCHEN, A., 2014. *Practice development workbook for nursing, health and social care teams.* Hoboken: Wiley.

DEWING, J. and McCORMACK, B., 2017. Creating flourishing workplaces. In: B. McCORMACK, and T. McCANCE, eds., *Person-centred practice in nursing and health care: Theory and practice.* Chichester: Wiley Blackwell.

DICKSON, C., van LIESHOUT, F., KMETEC, S., McCORMACK, B., SKOVDAHL, K., PHELAN, A., COOK, N. F., CARDIFF, S., BROWN, D., LORBER, M., MAGOWAN, R., McCANCE, T., DEWING, J. and STIGLIC, G., 2020. Developing philosophical and pedagogical principles for a pan-European person-centred curriculum framework. *International Practice Development Journal* pp.1-20. [Accessed 15 October 2020]. Available from: https://doi.org/10.19043/ipdj.10Suppl2.004

DOWNS, M., 1997. The emergence of the person in dementia research. *Ageing and Society.* vol. 17, no. 5, pp. 597-607.

DUCHSCHER, J., 2008. A process of becoming: A stage of New Graduate professional role transition. *The Journal of Continuing Education in Nursing.* vol. 30, no. 10, pp. 441-450.

DWYER, S.C. and BUCKLE, J.L., 2009. The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods.* vol. 8, no. 1, pp. 54-63.

EASTON, G., 2010. Critical realism in case study research. *Industrial Marketing Management*, vol. 39, no. 1, pp. 118-128.

EIDE, H., HAFSKJOLD, L., SUNDLING, V. and van DULMEN, S., 2017. Person-centred communication research: Systematic observation of real life practice. In: B. McCORMACK, S. van DULMAN, H. EIDE, K. SKOVDAHL, T. and H.EIDE, eds., *Person-centred healthcare research*. 1st ed. Chichester: Wiley Blackwell, pp. 191-200.

EWING, R. and SMITH, D., 2008. Doing, knowing, being and becoming: The nature of professional practice. In: J. HIGGS and A. TITCHEN eds., *Professional practice in health, education and the creative arts.* 2nd ed. London: Blackwell Science. pp. 14-28.

FAY, B., 1987. *Critical social science: Liberation and its limits.* New York: Cornell University Press.

FINLAY, L., 2002. Outing the researcher: the provenance, process, and practice of reflexivity. *Qualitative Health Research* [Online.]. vol. 12, no. 4, pp. 531–545 [Accessed 20 May 2020]. Available: https://doi.org/10.1177/10497320212912005.

FINLAYSON, J., 2005. *Habermas: A very short introduction.* Oxford: Oxford University Press.

FREIRE, P., 1996. *Pedagogy of the oppressed.* London: Penguin Books.

GALLAGHER, P., 2004. How the metaphor of a gap between theory and practice has influenced nursing education. *Nurse Education Today*. vol. 24, no. 4, pp. 263-268.

GHAFOURI, R. and OFOGHI, S., 2016. Trustworth and rigor in qualitative research. *International Journal of Advanced Biotechnology and Research.* vol. 7, no. 4, pp. 1915-1922.

GRIEVES, V., 2009. Aboriginal spirituality: Aboriginal philosophy. The basis of Aboriginal social and emotional wellbeing [Online]. NT: Cooperative Research Centre for Aboriginal Health [Accessed 20 June 2020]. Available from: https://www.pathwaysmh.com.au/Aboriginal_Philosophy.pdf

HABERMAS, J., 1987. *Theory of communicative action.* Boston: Beacon Press.

HAGERTY, B., LYNCH-SAUER, J., PATUSKY, K. and BOUWSEMA, M., 2013. An emerging theory of human relatedness. *The Journal of Nursing Scholarship Banner*, vol. 25, no. 4, pp. 291-296 [accessed 1 September 2016]. Available from: https://doi.org/10.1111/j.1547-5069.1993.tb00262.x

HARALDSDOTTIR, E., LLOYD, A. and DEWING, J., 2019. Relational ethics in palliative care research: including a person-centred approach. *Palliative Care and Social Practice*. [Accessed 2 October 2019]. Available from: http://doi.org10.1177/2632352419885384

HARDIMAN, M. and DEWING, J., 2019. Using two models of workplace facilitation to create conditions for development of a person-centred culture: A participatory action research study. *Journal of Clinical Nursing.* vol. 28, no. 15-16 pp. 2769-2781.

HERTZ, R., ed. 1997. *Reflexivity and voice*. CA: Thousand Oaks.

HEALTH EDUCATION AND TRAINING INSTITUTE, (HETI). 2013. *The superguide: A supervision continuum for nurses and midwives* [Online]. Sydney: HETI [Accessed 16 0ctober 2016]. Available from: https://www.heti.nsw.gov.au/education-and-training/our-focus-areas/nursing-and-midwifery/nursing-and-midwifery-superguide

HONDA, K., LEVETT-JONES, T., STONE, T. and MAGUIRE, J., 2016. Japanese nursing students' sense of belonging: A story of Uchi (insider) and Soto (outsider). *Nurse Education in Practice.* Vol. 20, pp. 85-92.

HOWIE, P. and BAGNALL, R., 2013. A critique of the deep and surface approaches to learning model. *Teaching in Higher Education*, vol. 18, no. 4, pp. 389–400.

IIDA, A., 2010. Developing voice by composing Haiku: A social-expressivist approach for teaching Haiku writing in EFL contexts. *English Teaching Forum*. vol. 48, no. 1, pp. 28-34.

ITALIA, S., 2016. *Strengths and weaknesses of Habermas' pragmatic realism.* Cagliari, CA: University of Cagliari: Department of Education, Psychology and Philosophy.

JACOBS, G., LIESHOUT, F., BORG, M. and NESS, O., 2017. Being a person-centred researcher: principles and methods for doing research in a person-centred way. In: B. McCORMACK, S. van DULMAN. H. EIDE, K. SKOVDAHL, and T. EIDE, eds. *Person-centred healthcare research*. 1st ed. Chichester, UK: Wiley-Blackwell, pp. 51-60.

JENKINS, D. and PRICE, B., 1996. Dementia and personhood: a focus for care? *Journal of Advanced Nursing.* vol. 24, no. 1, pp. 84-90.

KEMMIS, S., McTAGGART, R. and NIXON, R., 2013. *The action research planner: Doing critical participatory action research*. Singapore: Springer Verlag.

KERR, R. and STURM, D., 2019. Moving beyond “Insider or Outsider”: The ethnographic challenges of researching elite sport facilities in New Zealand. *Qualitative Inquiry*. vol. 25, no. 9-10, pp. 1137-1147.

KITCHENHAM, A., 2008. The evolution of John Mezirow's Transformative Learning Theory. *Journal of Transformative Education*, vol. 6, no. 2, pp. 104-123.

KITWOOD, T.M., 1997. *Dementia reconsidered: the person comes first.* Bristol: Open University Press.

KIVUNJA, C. and KUYINI, A., 2017. Understanding and applying research paradigms in educational contexts. *International Journal of Higher Education.* vol. 6, no. 5, pp. 26-41.

KOCKELMAN, P., 2013. *Agent, person, subject, self: A theory of ontology, interaction, and infrastructure.* Oxford, Oxford University Press.

KYRKJEBØ, J.M. and HAGE, I., 2005. What we know and what they do: nursing students’ experiences of improvement knowledge in clinical practice. *Nurse Education Today*. April, vol. 25, no. 3, pp. 167-175.

LANDERS, M. and McCARTHY, G. 2007. Person-centered nursing practice with older people in Ireland. *Nursing Science Quarterly*. January, vol. 20, no.1, p.78-84 [Accessed 20 July 2016]. Available from: https://doi-org.ezproxy.uow.edu.au/10.1177/0894318406296811

LE DANTEC, C.A.L. and DiSALVO, C., 2013. Infrastructuring and the formation of publics in participatory design. *Social Studies Science*. vol. 43, no. 2, pp. 241-264. [Accessed 7 February 2018]. Available from: https://doi.org/10.1177%2F0306312712471581

LEVAC, D., COLQUHOUN, H. and O'BRIEN, K. K., 2010. Scoping studies: advancing the methodology. *Implementation Science*: IS. vol. 5, pp. 5-69 [Accessed 3 April 2018]. Available from: https://doi.org/10.1186/1748-5908-5-69

LEVETT-JONES, T. and BOURGEOIS, S., 2015. *The Clinical Placement. 3ed.* Sydney: Churchill Livingstone: Elsevier.

LEVETT-JONES, T. and LATHLEAN, J., 2007. Belongingness: A montage of nursing students' stories of their clinical placement experiences. *Contemporary Nurse.* vol. 24, no. 2, pp. 162-174.

LEVETT-JONES, T. and LATHLEAN, J., 2009. The ascent to competence conceptual framework: An outcome of a study of belongingness. *Journal of Clinical Nursing.* vol. 18, no. 20, pp. 2870-2879.

LEVETT-JONES, T., LATHLEAN, J., HIGGINS, I. and McMILLAN, M., 2009. Staff - Student relationships and their impact on nursing students' belongingness and learning. *Journal of Advanced Nursing.* vol. 65, no. 2, pp. 316-324.

LINCOLN, Y. and GUBA, E., 1985. *Naturalistic inquiry.* Newbury Park, CA: Sage Publications.

MACK, L., 2010. The philosophical underpinnings of educational research. *Polyglossia* [Online]. [Accessed 3 June 2016]. Available from https://en.apu.ac.jp/rcaps/uploads/fckeditor/publications/polyglossia/Polyglossia_V19_Lindsay.pdf

MACKAY, M., 2016. Making sense of critical participatory action research. Reflections on the action research planner: Doing critical participatory action research. *International Practice Development Journal*, vol. 6, no. 2, pp.1-3 [Accessed 4 November 2020). Available from: https://doi.org/10.19043/ipdj.62.013

MACKAY, M. T., BROWN, R. A., JOYCE-McCOACH, J. and SMITH, K. M., 2014. The development of a model of education for casual academic staff who support nursing students in practice. *Nurse Education in Practice.* May, vol. 14, no. 3, pp. 281-285.

MACKAY, M., O'DONNELL, D., ESPIE, A and SKEI, K., 2021. Person-centredness in nursing education research. In: J. DEWING, B, McCORMACK, and T. MCCANCE, eds. *Person-centred Nursing Research: Methodology, Methods and Outcomes* Springer: In press.

MACKAY, M., RILEY, K. and DEWING, J. 2019. How do we consider the impact of clinical supervisor education? A participatory literature review. *International Practice Development Journal*, vol. 9, no. 1, pp.1-16 [Accessed 4 November 2020]. Available from: https://doi.org/10.19043/ipdj.91.007

MALLOY, D.C. and HADJISTAVROPOULOS, T., 2004. The problem of pain management among persons with dementia, personhood, and the ontology of relationships. *Nursing Philosophy.* vol. 5, no. 2, pp. 147-159.

MALTERUD, K., 2001. Qualitative research: Standards, challenges and guidelines. *The Lancet* [Online]. vol. 358, pp. 483-488. [Accessed 17 May 2019]. Available from: https://doi.org/10.1016/S0140-6736(01)05627-6

MANDELL, A. and HERMAN, L., 2009. In: J. MEZIROW, and E. TAYLOR, eds., *Transformative learning in practice: Insights from community, workplace and higher education*. San Francisco, CA: Wiley.

MANNINEN, K., HENRIKSSON, E.W., SCHEJA, M. and SILÉN, C., 2013. Authenticity in learning - nursing students' experiences at a clinical education ward. *Health Education.* vol. 113, no. 2, pp. 132-143.

MARCHEL, C. A., 2007. 'Learning to talk/talking to learn: Teaching critical dialogue'. *Teaching Educational Psychology*. vol. 2, no.1, pp. 1–15 [Accessed 4 March 2019]. Available from: https://search-ebscohost-com.ezproxy.uow.edu.au/login.aspx?direct=true&db=eric&AN=EJ817746

MASLOW, A.H., 1987. *Motivation and personality.* 3rd ed. India: Pearson Education.

McALLISTER, M., 2007. *Solution focused nursing: rethinking practice.* Basingstoke: Palgrave Macmillan.

McCORMACK, B., DEWING, J. and McCANCE, T., 2011. Developing person-centred care: addressing contextual challenges through practice development. *Online Journal of Issues in Nursing.* [Online]. May, vol. 16, no.3. [Accessed 2 September 2015]. Available from: https://www.researchgate.net/publication/51802780_Developing_person-centred_care_Addressing_contextual_challenges_through_practice_development

McCORMACK, B. and DEWING, J., 2019. International Community of Practice for Person-centred Practice: position statement on person-centredness in health and social care. *International Practice Development Journal*. vol. 9, no. 1, [Accessed 2 February 2020]. Available from: https://doi.org/10.19043/ipdj.91.003

McCORMACK, B., KARLSSON, B., DEWING, J. and LERDAL, A., 2010. Exploring person-centredness: a qualitative meta-synthesis of four studies. *Scandinavian Journal of Caring Sciences.* vol. *24, no.* 3, pp. 620–634.

McCORMACK, B., MANLEY, K. and TITCHEN, A., eds. 2013. *Practice Development in Nursing and Healthcare.* 2nd Ed. Oxford: Wiley-Blackwell.

McCORMACK, B. and McCANCE, T., eds. 2010. *Person-Centred Nursing: Theory and Practice.* Wiley-Blackwell.

McCORMACK, B. and McCANCE, T., eds. 2017. *Person-centred practice in nursing and health care: Theory and practice.* United States: John Wiley & Sons.

McCORMACK, B. and TITCHEN, A., 2006. Critical creativity: melding, exploding, blending. *Educational Action Research.* vol. 14, no. 2, pp. 239-266.

McCORMACK, B., van DULMAN, S., EIDE, H., SKOVDAHL, K., and EIDE, T., eds., 2017. *Person-centred healthcare research.* Chichester UK: Wiley Blackwell.

McCOY, M.A., LEVETT-JONES, T., and PITT, V., 2013. Development and psychometric testing of the Ascent to Competence Scale. *Nurse Education Today.* vol. 33, no. 1, pp. 15-23.

McMILLAN, F., KAMPERS, D., TRAYNOR, V, and DEWING, J., 2010. Person-centred care as caring for country: An Indigenous Australian experience. *Dementia: The International Journal of Social Research and Practice.* vol. 9, no. 2, pp. 163-167.

McNAUGHT, C. AND LAM, P., 2010. Using Wordle as a supplementary research tool. *The Qualitative Report.* vol. 15, no. 3, pp. 630-643. [Accessed 11 October 2018]. Available from: https://nsuworks.nova.edu/tqr/vol15/iss3/8

McNIFF, J. and WHITEHEAD, J., eds. 2011. *All you need to know about action research.* 2nd ed. London: SAGE Publication.

MERLEAU-PONTY, M., 1989. *Phenomenology of perception.* London: Routledge & Kegan Paul.

MERRIAM, A.H., 2004. The role of cognitive development in Mezirow's Transformational Learning Theory. *Adult Education Quarterly.* vol. 55, no. 1 pp. 60-68.

MEZIROW. J., 1978. Perspective transformation. *Adult Education Quarterly.* vol. 28, no. 10, pp. 100-110.

MEZIROW, J., 1990. *Fostering critical reflection in adulthood: A guide to transformative and emancipatory learning.* San Francisco: Jossey-Bass Publishers.

MEZIROW, J., 2000. *Learning as transformation: Critical perspectives on a theory in progress.* San Francisco: Jossey-Bass Inc.

MEZIROW, J., 2009. Transformative learning theory. In J. MEZIROW, and E. TAYLOR, eds. *Transformative learning in practice: insights from community, workplace, and higher education.* San Francisco, CA: Jossey-Bass, pp. 18-31.

MIDDLETON, R., 2013. Active learning and leadership in an undergraduate curriculum: How effective is it for student learning and transition to practice? *Nurse Education in Practice.* vol. 13, no. 2, pp. 83-88.

MILLER, E. and COOPER, S., 2016. A registered nurse in 20 weeks? *Australian Nursing and Midwifery Journal.* Vol. 24, no. 1, p.34. [Accessed 9 October 2020]. Available from: https://issuu.com/australiannursingfederation

MILLS, M.A. and COLEMAN, P.G., 1994. Nostalgic memories in dementia - a case study. *International Journal of Aging & Human Development.* vol. 38, no. 3, pp. 203.

MINGERS, J., 2014. The contribution of critical realism as an underpinning philosophy for OR/MS and systems. *Journal of the Operational Research Society.* vol. 51, no. 11, pp. 1256-1270.

MITCHELL, G. and AGNELLI, J., 2015. Person-centred care for people with dementia: Kitwood reconsidered. *Nursing Standard.* vol. 30, no. 7, pp. 47. [Accessed 31 June 2016]. Available from: http://doi.org/10.7748/ns.30.7.46.s47

NURSING MIDWIFERY BOARD OF AUSTRALIA (NMBA)., 2016. *Registered Nurse Standards for Practice - June 2016.* Canberra: NMBA. [Accessed 1 June 2016]. Available from https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements.aspx

O'DONNELL, D., COOK, N.F., and BLACK, P., 2017. Person-centredness in nursing education. In: B. McCORMACK, and T. McCANCE, eds., *Person-Centred practice in nursing and health care: Theory and practice, 2nd* ed. Oxford: Wiley-Blackwell, pp. 99-117.

O'DONNELL, D., McCORMACK, B., McCANCE, T. & McILFATRICK, S., 2020. A meta-synthesis of person-centredness in nursing curricula. *International Practice Development Journal.* vol.10. [Accessed 15 October 2020]. Available from: https://doi.org/10.19043/ipdj.10Suppl2.002

O'MARA, L., McDONALD, J., GILLESPIE, M., BROWN, H. and MILES, L., 2013. Challenging clinical learning environments: Experiences of undergraduate nursing students. *Nurse Education in Practice*. vol. 14, no. 2, pp. 208-213. [Accessed 6 September 2016]. Available from: http://doi.org/10.1016/j.nepr.2013.08.012

OLIVEROS P., 2005. *Deep listening: A composer's sound practice*. IN: iUniverse.

Ó LÚANAIGH, P., 2015. Becoming a professional: What is the influence of registered nurses on nursing students' learning in the clinical environment? *Nurse Education in Practice*. vol. 15, no. 6, pp. 450-456.

PAVLICEVIC M, and IMPEY A., 2013. Deep listening: towards an imaginative reframing of health and well-being practices in international development. *Arts Health*. August, vol. 13; no. 5, pp. 238-252. [Accessed 2 June 2020]. Available from: http://doi:10.1080/17533015.2013.827227

PERMATASARI, I.E., 2016. Analysis of feminism in Maya Angelou's poems by using historical and biographical approaches. *Journal Ilmiah Bahasa Dan Sastra*vol. vol. 3, no. 2, pp. 152-174. [Accessed 2 March 2020]. Available from: http://doi.org/10.21067/jibs.v3i2.1467

PIPER, A. M. and LAZAR, A., 2018. Co-design in health: What can we learn from art therapy? *Interactions*. vol. 25, no. 3, pp. 70-73 [Accessed 2 January 2019]. Available from: https://doi.org/10.1145/3194353

POLIT, D.F. and BECK, C.T., 2017. *Nursing research: Generating and assessing evidence for nursing practice.* 10th ed. Philadelphia: Wolters Kluwer Health.

POPOV, L. K., 2004. *A pace of grace: The virtues of a sustainable life*. London: Plum, Penguin Books.

PROBST, B., 2015. The eye regards itself: Benefits and challenges of reflexivity in qualitative social work research. *Social Work Research.* March, vol. 39, no. 1, pp. 37–48 [Accessed 2 September 2018]. Available from: https://doi.org/10.1093/swr/svu028

REID, C., 2012. Developing a research framework to inform an evidence base for person-centred medicine: keeping the person at the centre. *European Journal for Person Centred Healthcare*. vol. 2, no. 1, pp. 336-342.

RENNIE, K. and KINSELLA, N., 2020. Supporting transformational learning processes for person-centred healthcare research in doctoral education: a critical creative reflection. *International Practice Development Journal.* May. vol. 10, no. 1, pp. 1-12. [Accessed 1 June 2020]. Available from: https://doi.org/10.19043/ipdj.101.010

ROGERS, C. and FARSON, R., 1979. Active listening. In: D. KOLB, I. RUBIN, and J. MACINTYRE, eds., *Organizational Psycholo*gy. New Jersey: Prentice Hall, pp. 168-180.

RODERICK, R., 1986. *Habermas and the foundations of critical theory.* Hampshire, US: McMillian Publisher.

SABAT, S., 2001. *The experience of Alzheimer's disease: Life through a tangled veil.* Oxford: Blackwell.

SALIFU, D. A., GROSS, J., SALIFU, M. A. and NINNONI, J. P. K., 2018. Experiences and perceptions of the theory-practice gap in nursing in a resource-constrained setting: A qualitative description study. *Nursing Open*. vol.6, pp. 72–83. [Accessed 20 September 2018]. Available from: https://doi.org/10.1002/nop2.188

SANDERS, K., MARRIOTT-STATHAM, K., MACKAY, M., McMILLAN, A., RENNIE, K., ROBINSON, B. & TEELING, S P., 2020. The Student International Community of Practice: a critical reflection on the shared experience of being a member, using creative hermeneutics. *International Practice Development Journal*. May, vol. 10, no. 1, [Accessed 1 June 2020]. Available from: https://doi.org/10.19043/ipdj.101.011.

SAYER, A., 1992. *Method in social science: A realist approach.* 2nd ed. London: Routledge.

SCHEIN, E., 1993. On dialogue, culture, and organizational learning. *Organizational Dynamics*. vol. 22, pp. 40-51.

SCRUTON, R., 2017. *On human nature.* Oxfordshire: Princeton University Press.

SEDGWICK, M.G. and KELLETT, P., 2015. Exploring masculinity and marginalization of male undergraduate nursing students' experience of belonging during clinical experiences. *Journal of Nursing Education*. vol. 54, no. 3, pp. 121-129.

SINGER, P., 1979. *Practical ethics.* Cambridge: Cambridge University Press.

SMITH, C., 2010. *What is a person?* 7th ed. USA: The University of Chicago Press.

SMITH, L. and COLEMAN, V., eds., 2009. *Child and family-centred healthcare: Concept, theory and practice.* 2nd ed. United Kingdom: Palgrave Macmillan.

SNOEREN, M.M.W.C., NIESSEN, T.J.H. and ABMA, T.A., 2012. Engagement enacted: Essentials of initiating an action research project. *Action Research*. vol. 10, no. 2, pp. 189-204.

STRYDOM, P., 2007. A cartography of contemporary cognitive sociology. Special issue. *European Journal of Social Theory.* vol. 10, no. 3, pp. 339-356.

SUSEN, S., 2009. The philosophical significance of binary categories in Habermas's discourse ethics. *Sociological Analysis.* vol. 3, no. 2, pp. 97-125.

SYMON, D. and JUSAITIS, M., 2007. Sturt Pea - a most splendid plant. Adelaide: SA Government.

TAYLOR, E. and CRANTON, P., 2012. *The handbook of transformative learning: Theory, research and practice.* San Francisco: Josey-Bass.

THE VIRTUES PROJECT., 2020. *Defining the virtues* [Online]. [Accessed 19 May 2020]. Available from: https://virtuesproject.com/virtuesdef.html#

TITCHEN, A., HIGGS, J. and NEVILLE, V., 2001. Professional practice and knowledge. In: J. HIGGS, and A. TITCHEN, eds. *Practice knowledge and expertise in the health professions*. England: Butterworth-Heinemann.

TITCHEN, A. and McCORMACK, B., 2010. Dancing with stones: critical creativity as methodology for human flourishing. *Educational Action Research* vol. 18, no. 4 pp. 531-554.

TITCHEN, A., CARDIFF, S. and BIONG, S., 2017. The knowing and being of person-centred research practice across worldviews: An epistemological and ontological framework. In: B. McCORMACK, S. van DULMAN, H. EIDE, K. SKOVDAHL, and T. EIDE, eds. *Person-centred healthcare research.*1st ed. Chichester: Wiley Blackwell. pp. 31-50.

TORCHIA, J., 2008. *Exploring personhood: An introduction to the philosophy of human nature.* Maryland: Rowman and Littlefield Publishers.

TSIMANE, T.A. and DOWNING, C., 2020. Transformative learning in nursing education: A concept analysis. *International Journal of Nursing Sciences.* January 2020, vol. 7, no. 1, pp. 91-98.

UNGUNMERR, M., 1988. *DADIRRI* [Online]. [Accessed 5 July 2016]. Available from: https://www.miriamrosefoundation.org.au/about-dadirri/dadirri-text

van DULMEN, S., McCORMACK, B., EIDE, T., SKOVDAHL, K. and EIDE, H., 2017. Future Directions for Person-centred healthcare research In: B. McCORMACK, S. van DULMEN, H. EIDE, K. SKOVDAHL, and T. EIDE, eds., *Person-centred healthcare research.* 1st ed. Chichester: Wiley-Blackwell, pp. 209-218.

WALSH, T., 2010. *Solution-Focused helper: Ethics and practice in health and s*ocial care. Berkshire: Open University Press.

WATSON, J., 1999. *Post modern nursing and beyond*. Edinburgh, Scotland: Churchill-Livingstone: Harcourt-Brace.

WILCOCK, A., 2002. Reflections on doing, being and becoming. *Australian Occupational Therapy Journal.* vol. 46, no. 1 pp. 10.

WILLIAMS, C. and McCORMACK, B., 2017. Learning to be an Effective Person-Centred Practitioner. In: B. McCORMACK, S. van DULMEN, H. EIDE, K. SKOVDAHL, and T. EIDE, eds., *Person-centred healthcare research.* 1st ed. Chichester: Wiley-Blackwell, pp. 169-179.

WILLOUGHBY, J.F. and LIU, S., 2018. Do pictures help tell the story? An experimental test of narrative and emojis in a health text message intervention. *Computers in Human Behavior*. vol. 79, pp. 75-82.

WILSON, V. and McCORMACK, B., 2006. Critical realism as emancipatory action: The case for realistic evaluation in practice development, *Nurse Philosophy.* vol.7, no.1, pp.45-57.

Appendices

Appendix A

Email - Miriam- Rose Foundation – Approval to use of Dadirri

From: Eleesa Zlatic
To: Maria Mackay
Subject: Re: re PhD use of Dadirri
Date: Wednesday, 29 April 2020 12:36:59 PM
Attachments: image003.png

Hello Maria,

Thank you for your email. I spoke with MIriam Rose, and she is very supportive of your request. Could you please acknowledge Dadirri appropriately by using the quote below.

Thank you for your kind offer of making a donation to the Miriam Rose Foundation, that would be much appreciated. Here is the link to the website, where the donate link can be found on the homepage. http://miriamrosefoundation.org.au/

> "Dadirri is a word from the Ngangikurungkurr language. Miriam Rose is an Elder from the Nauiyu community, Daly River, Northern Territory."

Kind regards,
Eleesa Zlatic
0421 573 555

Appendix B

Publication – How do we consider the impact of clinical supervisor education? A participatory Literature review

International Practice Development Journal

Online journal of FoNS in association with the IPDC and PcP-ICoP (ISSN 2046-9292)

CRITICAL REVIEW OF LITERATURE

How do we consider the impact of clinical supervisor education? A participatory literature review

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Abstract

Background: This research forms the initial part of a PhD research study, based in the critical paradigm, with an emphasis on developing education strategies that impact on learning in the non-classroom setting. The focus of this article is the education required to enable clinical supervisors to undertake their role supporting nursing students in clinical practice.

Aims: There are two aims of this literature review. First, to determine what peer-reviewed, published literature reveals concerning effective learning and teaching strategies for clinical supervisor education. Second, to gain an understanding from a group of clinical supervisors of their perspective on the literature review findings, and develop recommendations for their preparatory education.

Methods: This research used a literature review with a participatory phase built in. A traditional review was completed and then extended to include the clinical supervisors reviewing the findings, providing their perspectives and developing recommendations for their own future education development.

Findings: During phase one of the research, 22 peer-reviewed articles were included for review and four themes identified and explored. In phase two, 36 clinical supervisors provided their perspectives on these themes. They highlighted the need for a variety of modalities for education to ensure supervisors have shared values, knowledge and skills to work in clinical practice with nursing students and, more broadly, to influence the development of person-centred learning cultures.

Conclusions: The literature review revealed a limited amount of peer-reviewed literature. Further, there is little published literature on person-centred situated education for clinical supervisors. When evidence is shared with clinical supervisors, they can contribute to designing their education needs.

Implications for practice:

- Overall, as person-centred curricula develop, there will be a need to focus on transferring the person-centred pre-registration curriculum into the clinical practice context
- There is presently both a gap and an opportunity for person-centred research and development with clinical supervision

Keywords: person-centred curriculum, participatory, clinical supervision, clinical supervisors, pre-registration nursing

Introduction

Creating person-centred learning cultures in nursing education, in the classroom and in practice, is a challenge for the university and healthcare sectors in Australia and internationally (O'Donnell et al., 2017). The underlying premise for this literature review is a belief that nursing students supervised by clinical supervisors who draw on person-centred interventions are better enabled to reach their full potential. It is proposed that education and learning underpinned by person-centredness contribute to clinical supervisors' understanding of person-centred practice, and therefore impacts positively on their influence on the creation of person-centred learning cultures. The specific stimulus or trigger for this literature review was an observation that enabling nursing students in clinical practice, through the use of person-centred learning and teaching strategies, has been transformational for both clinical supervisors and nursing students. Transformational in this context refers to transformative learning, which is learning that enables a change or growth in understanding (Mezirow, 1978). This experience has led us to consider the following research question: 'How do the learning and teaching strategies provided to clinical supervisors impact on their ability to be effective person-centred clinical supervisors?' This question led onto a literature review that sought to inform the development of a revised curriculum for pre-registration nursing students.

Aims

The aims of this literature review were to:

- Determine what the peer-reviewed published literature reveals concerning effective learning and teaching strategies for clinical supervisor education
- Gain an understanding from a group of local clinical supervisors of their perspective on the literature review findings, and develop with them recommendations for their education to prepare for working with nursing students in clinical practice

Background

Our research was situated in the critical paradigm and took a person-centred approach to the research design and implementation processes in keeping with ideas set out by McCormack et al. (2017). Consistent with critical paradigm research, consideration of the context where the research was located is necessary (McNiff et al., 2011). In this study, this was a higher education setting in New South Wales. Highlights from this research may be beneficial to others as many universities and healthcare providers are grappling with how to improve the support provided to nursing students during their clinical placement (Giddens and Eddy, 2009; McAllister and McKinnon, 2009) and with the rise of person-centred curricula. The responsibility for clinical supervision with nursing students in clinical practice within Australia, lies with the universities, which have a variety of models (Giddens and Eddy, 2009). Our research has been situated within a model of clinical supervision for pre-registration nurses known as clinical facilitation. The model includes university-employed casual academic staff, known as clinical supervisors, who are registered nurses and have the role of supervision and assessment of nursing students during their clinical placement. They are supernumerary to the registered nurses who provide care and have no association with the host healthcare environment. The benefits of developing positive relationships between nursing students and their clinical supervisors has been linked to increasing motivation and learning during the placement experience, and associated with a willingness to stay within the nursing profession on graduation (Levett-Jones and Lathlean, 2009). It is therefore imperative that clinical supervisors are adequately prepared to undertake their role.

Within healthcare internationally, the concept of person-centredness is increasingly being considered, as 'the person' is becoming more of a central focus (World Health Organization, 2007; McCormack et al., 2011). This being so, healthcare systems require clinical professions to be effectively prepared to work in increasingly person-centred ways. However, O'Donnell et al. (2017) report that no attention has been paid to personhood and person-centredness in designing educational curricula. Specifically, there is minimal evidence of person-centredness being integrated into nursing education curricula. For example, Cook (2017) was unable to identify any person-centred educational frameworks within pre-

registration curricula at this point in time. The International Community of Practice for Person-centred Practice Research (2017) has developed a position statement in which it sets out the key considerations in the development of a person-centred curriculum. The definition of person-centredness drawn on by PcP-ICoP is:

> *'An approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by the values of respect for persons, individual rights to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development'* (McCormack and McCance, 2017, p 3).

This definition offers an insight into person-centredness rather than setting out what person-centredness is in its entirety. Two of its core ideas are healthful relationships and flourishing. Healthfulness was first proposed by Seedhouse (1986), as the totality of health and wellbeing understood within a social context. McCormack (2012) builds on this by suggesting that healthful relationships are the totality and quality of relationships and social engagement where relationships play a central contribution to health and wellbeing. Flourishing can be thought of as a process of creative transformation of personhood, enabled through a continuous and dynamic expansion of the person primarily though the quality of personal-social connections in the world (McCormack, 2012). The nucleus of this idea can be traced back to Aristolian philosophy in which, derived from a virtue ethics foundation, living an engaged and virtuous life was considered as the greatest human good that could be achieved in life (McCormack and McCance, 2017). Therefore, there is a need to consider how we prepare clinical supervisors to have an understanding of their values and beliefs and their role in the creation of healthful relationship with nursing students in clinical practice. Internationally, there is a gap in the literature in terms of how to best develop, implement and evaluate person-centred pre-registration nursing curriculum (O'Donnell et al., 2017). At the university where this research was undertaken there are preparations to move the pre-registration nursing curriculum towards a person-centred approach, drawing on the person-centred framework of McCormack and McCance (2017). Inherent within the philosophical approach is that clinical supervisors who support nursing students in clinical practice have skills and knowledge in person-centred ways of working and being (O'Donnell et al., 2017). There are a wide variety of supervision models in place to support nursing students during their clinical placements. Unlike the UK, which has a standard approach to clinical supervision for pre-registration nursing students, in the Australian context each university determines the model and holds the responsibility to educate and support clinical supervisors (Giddens and Eddy, 2009; McAllister and McKinnon, 2009). The university in this research includes the development of an education programme for clinical supervisors that provides them with skills in person-centred supervision.

The clinical supervisors' role is part of creating coherent person-centred learning cultures in practice for students. The need to achieve this will grow as the movement towards a more person-centred curriculum evolves (Dewing, 2009). At the university, clinical supervisors participate in biannual workshops that aim to provide education and support to them in their role. At these workshops, clinical supervisors often express feelings of being underprepared for the complex interpersonal communications required in their role (Mackay et al., 2014). The findings of this research aim to inform the future development of education that better prepares clinical supervisors to provide person-centred learning and support to nursing students during their clinical placement.

Methods

This two-phase literature review included a traditional and participatory element. The first phase comprised a literature review using a systematic review process (Booth et al., 2012). This initial phase explored what the literature revealed concerning the impact of clinical supervisor education on supervisors themselves. The second phase drew on two core principles of participatory action-oriented research considered as necessary in the development of a 'living' person-centred curriculum

(McCormack et al., 2017; PcP-ICoP, 2017): the need for a safe space and accepting different degrees of participation (Wicks and Reason, 2009).

Phase 1: Literature review

Search strategy

A five-step method was completed, as defined by Booth et al. (2012): scoping the search; conducting the search; bibliography review; verification; and documentation. This method guaranteed the identification of contemporary literature in peer-reviewed publications, with the search limited to articles in the English language. The databases used were Medline and Scopus. Following advice from a university librarian, no further databases were explored as it was considered that the two included covered all key nursing research journals. The choice of database was based on the overlap of searches in all nursing and education databases, where Hill (2009) argues that the overlap of Scopus with databases such as CINAHL is greater than with Medline. Keywords for the review were agreed on following discussion with the librarian as shown in the table below.

Table 1: Search terms

KEY WORDS
Education or professional development programs or frameworks or continuing professional development
and
Clinical supervis* or supervis* or registered nurse or preceptor or facilitator or mentor or group supervis*
and
Effective or quality outcomes or evaluation or effectiveness or graduate
and
Strateg* or methods or plans or frameworks/model or policy

The retrieved literature was assessed against the inclusion and exclusion criteria. Publications included were those that used an identifiable research method to evaluate the effectiveness of educational strategies. Publications were mainly excluded mainly if they did not specifically evaluate learning and teaching strategies or were not research based. The final literature was then subjected to a broad-based thematic identification and analysis using Braun and Clarke's (2006) six-phase method, by all three authors. Authors one and two (MM and KR) carried out an initial analysis independently and then discussed and merged their findings, with the third author (JD) offering a critique and refinement of the themes. Braun and Clarke's method can be used independently of theory; it enables a thematic analysis that directs identification, analysis and reporting of patterns or themes within the evidence. Importantly for this study, the model helped researchers to move outside theming from a set of questions, to analyse across the evidence retrieved to find repeated patterns.

Phase 2: The participatory element

Participants were the clinical supervisors employed as casual academics by the university. Clinical supervisors were recruited through an education workshop, once institutional ethical approval had been agreed. All clinical supervisors employed by the university were invited to attend the workshop and there were no exclusion criteria required. All participants were provided with advance information about the study and written consent. The researchers devised a workshop plan drawing on the methodological principles of inclusion, participation and active learning. Terms of engagement for the workshop were agreed, with an emphasis on co-creating a safe space to share ideas. The workshop was facilitated by the principle researcher and one other academic staff member who acted as a process observer and note taker. The workshop began with sharing the key findings from the literature review, verbally and in handout format. Following this, the clinical supervisors were challenged with a set of questions about each provisional finding and invited to respond. To achieve this, they formed small groups facilitated by members of the research team. It was notable that everyone in the groups drew on and shared stories about their experiences working as clinical supervisors in the clinical

environment. Facilitators encouraged the meaning of stories or parts of the stories to be clarified and related to evidence in the literature where possible. The participants then came together for a group discussion to summarise their expert opinion and gain consensus about the provisional findings within the literature. As many of the contributions as possible were noted and later transcribed by the observer/note taker. From the write-ups it could be seen that simple note taking had not captured all the ways in which the clinical supervisors had contributed. The notes were analysed in regard to how the participants interpreted the themes and the evidence, and what sense they made of it in relation to clinical supervision and themselves as supervisors. It was also possible to identify gaps in the literature and extract recommendations made by the clinical supervisors for future education design and delivery. Evaluation of the workshop indicated the clinical supervisors all learned something of significance to them and thus found taking part in the research beneficial.

Ethical considerations

Ethical approval was granted by the university research ethics committee. The main ethical considerations were to address any concerns relating to the participants as casual employees and to some of them also being postgraduate students of the university. In particular, we anticipated that some participants may feel the need to take part in the project as a way of ensuring continued employment or improving their educational experience. To ensure that the ethical principle of justice (National Health and Medical Research Council, 2007) was considered, we provided clear information about the right to not take part or to withdraw from the study and matters relating to confidentiality on the participant information sheet and on the consent form. To reduce further any perception of coercion, the initial contact was made by a research assistant via email, rather than by any of the researchers.

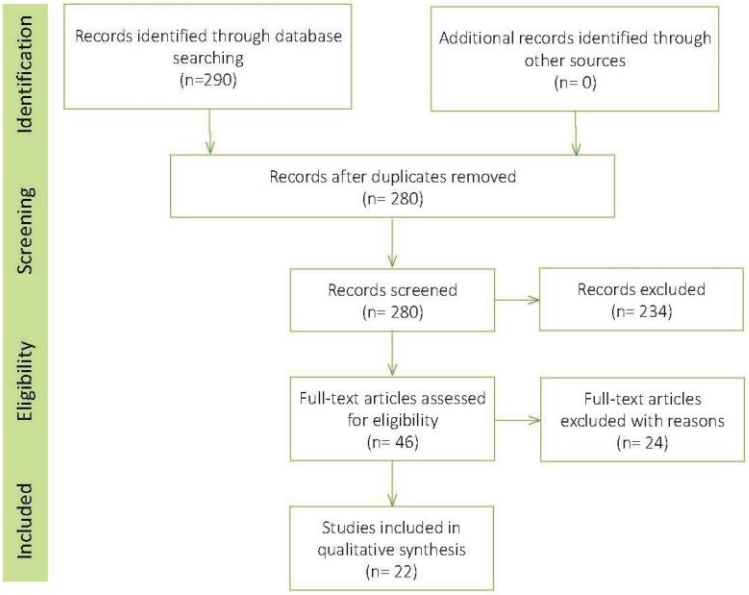
Findings

Phase 1: Literature review

A total of 228 peer-reviewed publications were identified by the database search. All abstracts were reviewed against the agreed inclusion and exclusion criteria by two of the researchers separately. At this point, 46 articles were identified for full review, following which, 24 were excluded; although the authors of these publications discussed educational strategies there was no evidence of any evaluation of the effectiveness of education strategies either from an educational or application to practice perspective. The final 22 were largely qualitative in nature, although several had a multiple-methods design where some quantitative data were included. Publications included in the literature review were from the US (11), Australia (7), Canada (2), UK (1), and Sweden (1), giving an international perspective to the review. Only four studies had any theoretical or philosophical perspective: adult learning principles; situated learning theory; caring theory; and critical social science. Four key themes were identified from analysing the literature:

- Education and the influence on attitudes, knowledge and skills of clinical supervisors
- Varying the modes of education to better support sustainable learning
- Clinical supervisors' beliefs about face-to-face networking
- Ongoing learning from education for clinical supervisors as a requirement to create a positive learning culture

Figure 1: PRISMA search strategy



Theme 1: Education and its influence on attitudes, knowledge and skills

This first theme was the most common, with many articles demonstrating that education positively influences the attitudes, knowledge and skills of clinical supervisors. Twelve of the 22 publications identified outcomes related to this finding. According to two authors, (Phillips, 2006; Mackay et al., 2014.), quantitatively based findings demonstrated that developing clinical supervisors' attitudes, knowledge and skills through education strategies enabled them to better influence the learning environments for nursing students. Smedley et al. (2010), in a quantitative survey, found clinical supervisors reported that education enlightened them and changed their attitude to supporting nursing students in a more positive way, helping them to develop positive short-term relationships. Three studies found that clinical supervisors' participation in educational opportunities was an effective approach to enhancing their skills and confidence (Nicol and Young, 2007; Ford et al., 2013; Browning and Pront, 2015). A number of authors writing from a qualitative and inquiry-based perspective identified that education is an effective way to enable the generation of new thought, increasing participants' ability to think and reflect critically (Schaubhut and Gentry, 2010; Sandu and Halm, 2011; Ford et al., 2013; Paliadelis et al., 2014).

Theme 2: Varying the modes of education to better support sustainable learning

The second theme was evident in 10 of the 22 articles, inferring that providing clinical supervisors with a variety of modes of education supports sustainable learning. The majority of studies employed a qualitative approach. Phillips (2006), in a review of the education literature for clinical supervisors, found that clinical supervisors preferred education that used blended modes of delivery. Then, two evaluation studies found that experiential learning increased clinical supervisors' skills, empathy and enabled understanding of challenging content (Nicol and Young, 2007; Beecroft at al., 2008). However, we found a strong narrative exists in the literature that advocates online education as the primary

mode for education. These studies claimed online learning was flexible and convenient (Phillips, 2006; Bradley et al., 2007; Burns and Northcott, 2009; Ayala et al., 2014; Blum, 2014; McColgan and Rice, 2014; Browning and Pront, 2015) and contributed to self-directed learning by enabling clinical supervisors to learn at their own pace (Blum, 2014). Several authors stated that a blend of face-to-face and online education strategies was preferred, as clinical supervisors valued connecting with colleagues and other stakeholders in person (Phillips, 2006; Bradley et al., 2007; Burns and Northcott, 2009; Luhanga et al., 2010; Ayala et al., 2014; Blum, 2014; McColgan and Rice, 2014; Browning and Pront, 2015).

Theme 3: learning is gained by networking with others at education sessions

Networking was identified in nine of the publications included in our review, all of which featured a qualitative research design. Overwhelmingly, the findings emphasised how positive and collaborative relationships were promoted between health services, university staff and clinical supervisors during education sessions (Luhanga et al., 2010; Schaubhut and Gentry, 2010; McColgan and Rice, 2012; Mackay et al., 2014). The development of such relationships is particularly important for clinical supervisors as they often work in isolation and at a distance from the university (Mackay et al., 2014). Face-to-face sessions, such as workshops, were seen as enhancing the perception of a collegial environment (Woloschuk and Raymond, 2012) and encouraging the building of supportive networks (Luhanga et al., 2010; Mackay et al., 2014). These networks were identified by clinical supervisors as crucial elements to knowledge development and confidence in their role. Feeling part of a social community that shared experience-based stories enabled the clinical supervisors to actively reflect on their past experiences (Andrews and Ford, 2013), while also learning from others' experiences (Bradley et al., 2007; Ayala et al., 2014).

Theme 4: ongoing learning from education for clinical supervisors is required to create a positive learning culture

Achieving learning outcomes from the education provided for clinical supervisors was argued to be fundamental to the creation of positive learning cultures in five of the 22 articles. This theme suggests that the clinical supervisors who attended education on their role developed skills and improved their ability to create positive learning environments (Smedley et al., 2010; Ford et al., 2013). Clinical supervisors who felt supported themselves were found to be more 'student-centred' and thus more able to influence a positive learning environment (Borch et al., 2013). A key finding of a pre-post test survey was that well-educated clinical supervisors are the key to developing a positive learning culture in the clinical setting (Davis et al., 2009).

Table 2: Thematic analysis grid

Author, year/ country	Aim	Design/method	Major findings relevant to educational strategies for clinical supervisors
Andrews et al., 2016/ Australia	To explore the practice experiences of clinical supervisors providing a voice for nurses undertaking the role, a group who up until now has been silent	To explore the potential role of online learning in supporting and training both urban and rural field instructors	• It was evident that a spirit existed amongst the clinical facilitator group and there were benefits associated with sharing ideas and stories • Participants identified the need for mentors to support and guide them in their role as facilitating is an autonomous position that is often carried out in isolation • Participants wanted to receive feedback on their performance
Ayala et al. 2014/US	To explore the potential role of online learning in supporting and training both urban and rural field instructors	Qualitative interviews	• Participants reported online learning to be convenient and cheap, however they still would prefer face to face training • Hearing from other facilitators experiences during educational interventions enhanced their feelings of support
Beecroft et al., 2008/US	To evaluate a team approach to preceptor new graduate nurses	Evaluation study	• Experiential learning style allows for more difficult content to be more readily explored
Blum, 2014/ US	To evaluate preceptor perception of support using educational podcasts	Correlational research design	• There was a very strong correlation by the perception of support and the satisfaction with the role of clinical supervisor • Online learning was reported to be flexible • Participants with the fewest years of experience reported the greatest gains in feelings of support after viewing the podcasts
Borch et al., 2013/ Sweden	To investigate the preceptors' views on their ability and satisfaction in the role before and after taking part in group supervision during one year and to describe their perception of the supervision model used	Palliative care clinicians Descriptive and comparative study	• Participants did not report a significant increase in their KSA however they did report being able to undertake the role of supervisor in a more appropriate way • Supervision of clinical supervisors during the placement period enables them to be more student centred • Reflecting upon ones own experiences together with colleagues can provide valuable support to each other
Bradley et al., 2007/US	To explore a blended learning approach to preceptor role preparation	Qualitative survey	• Blended learning is an effective strategy • Access to technology can be an issue for online sections of the learning • Face to face sessions enhanced the on line content
Browning and Pront., 2015/ Australia	To provide a means of support to clinical supervisors of nursing students through a computer based clinical supervisor educational package (CSEP) and to test the effectiveness of the CSEP	Mixed methods	• Online education enabled clinical supervisors to empower students to lead their learning • Online learning supported clinical supervisors to communicate more proactively with students and to promote critical thinking • Effectiveness of student supervision is enhanced when education providers and health care workers work together
Brunt and Kopp, 2007/US	To assess the impact of preceptor and orientee learning styles	Descriptive study	• Participant awareness of their own learning style will help each other relate more effectively • When participants had access to a learning style tool they were able to identify learning styles and ultimately tailor the learning experience
Burns and Northcott, 2009/US	To evaluate the impact of a Nursing Preceptor Programme (NPP)	Pre and post test	• Online modules are a convenient way to provide education to clinical supervisors • Systematizing the training of clinical supervisors helps to ensure a more uniform experience for both student and preceptor
Davis et al., 2015/US	To evaluate changes in self concept for the knowledge, skills and attitudes toward inter professional teamwork of facilitators who participated in training and an inter-professional team training event	Quasi-experimental design	• Well educated clinical supervisors are the key to interprofessional support in the clinical setting • Participants felt the ITTD facilitator training session and facilitation during the event had a strong impact on their knowledge, skills, and attitudes for inter-professional teamwork

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Table 2: Thematic analysis grid *(continued)*

Author, year/ country	Aim	Design/method	Major findings relevant to educational strategies for clinical supervisors
Ford et al.,2013/ Australia	To evaluate a preceptorship workshop for nurses and midwives structured using a practice development framework	Practice development	• Experiential learning is the most effective way to encourage critical reflection on and in practice to build a knowledge base and promote confidence among preceptors • Practice development is an effective method for clinical supervisors to flourish and create positive learning environments • Emancipatory learning enabled clinical supervisors to identify their hopes, fears and expectations
Luhanga et al., 2010/Canada	To explore and describe preceptor role support and development within the context of a rural and northern mid-sized Canadian community	Qualitative descriptive study	• Paper-based resources were used only 40% of the time and were evaluated as being not useful • Supervisors requested education on role clarification and how to evaluate student performance • More frequent communication between university and supervisors was identified as being desired by supervisors • Face to face workshops with university faculty could serve to create stronger communication and partnerships between members of the preceptor team
Mackay et al., 2014/Australia	The development of a model of education for casual academic staff who support nursing students in practice	Participatory action research	• Workshop participation demonstrated an increase in clinical supervisors understanding of nursing student programme of study and clinical placement requirements • Workshop participation was recognised as a networking opportunity for clinical supervisors • Practice development is an effective tool for enabling clinical supervisors to increase their knowledge and skills
McColgan and Rice., 2012/UK	To describe the development of an online training programme for clinical supervision from inception through to delivery	Descriptive	• Collaboration between faculty and supervisors is important • Online learning modules provide flexibility for learners but there is a concern this encroaches on time outside paid work hours • Technology is a useful adjunct to traditional teaching methods
Nicol and Young, 2007/ Australia	To evaluate a one-day skill-training programme that aims to increase graduate nurse preceptor skills	Evaluation study	• Experiential learning increased participants awareness and ability in empathy, skills acquisition and learning opportunities
Ottolini et al., 2010/US	To determine the correlation between the frequency which faculty displayed ESP behaviours and student perception of teaching effectiveness	Quantitative survey and observational	• Education for clinical supervisors is required to effectively implement a model of student feedback or support
Palladelis et al., 2014/Australia	To report on the development and evaluation of an innovative online learning programme aimed at enhancing student and clinical supervisors' preparedness for effective workplace-based learning	Narrative	• Story telling is an effective learning strategy to help clinical supervisors connect emotionally with the content • Story telling promotes reflection and encourages deep rather than surface learning
Phillips, 2006/ US	To identify what is already known about preceptor preparation	Literature review	• The main attractions of online learning for the preceptor are access and convenience • Offering online preceptor programmes can accommodate nurses' busy schedules and enhance knowledge, using anytime, anywhere learning
Sandau and Halm, 2011/US	To examine the hospital-wide effect of a mandatory 8 hour nurse preceptor workshop on preceptors and orientees	Mixed method	• Participating in workshop education helps clinical supervisors increase their knowledge and skills related to their role • Participating in workshop education increased clinical supervisors' enthusiasm for their role • Participating in workshop education increased clinical supervisors' ability to overtly encourage students to apply critical thinking during their placement • Many preceptors felt that the workshop increased their enthusiasm for precepting
Schaubhut and Gentry, 2010/US	Explore pertinent topics that assist nurses to teach students as well as the methods used to hold and conduct the learning experience	Descriptive	• Developing partnerships with education and health care providers is essential to ensure education is effective • Education sessions help clinical supervisors develop skills assisting students to apply critical thinking in practice

Table 2: Thematic analysis grid *(continued)*

Author, year/ country	Aim	Design/method	Major findings relevant to educational strategies for clinical supervisors
Smedley et al., 2010/Australia	To explore the perceptions of practicing preceptors from one health care facility after completion of a specially designed preceptor programme	Qualitative survey	• Workshop education increased how clinical supervisors view themselves in the role and their skills and knowledge related to their role • Education of clinical supervisors improves the clinical environment for students to learn in • Workshop education changed clinical supervisors' attitude to students nurses in a positive way, this helps them to develop positive short term relationships with students
Woloschuk and Raymond, 2012/ Canada	To evaluate a workplace preceptor training course for pharmacists and pharmacy technicians in a large regional health authority	Qualitative	• Experienced clinical supervisors continue to benefit from attending education sessions as participants learn from each other • Finding time to attend education is one of the greatest challenges

Table 3: Themes within articles

Author (year)	Education influences attitudes, knowledge and skills	Learning is gained by networking with others at education session	Varying the modes of education is more likely to support sustainable learning	Ongoing learning from education for clinical supervisors is required to create a positive learning culture
Andrews et al. (2013)		X		
Ayala et al. (2014)		X	x	
Beecroft et al. (2008)			X	
Blum (2014)			X	
Borch et al. (2013)	X			X
Bradley et al. (2007)		X	X	
Browning and Pront (2015)	X	X	X	
Brunt and Kopp (2007)				X
Burns and Northcott (2009)			X	
Davis et al. (2015)	X			X
Ford et al. (2013)	X			X
Luhanga et al. (2010)		X	X	
Mackay et al. (2014)	X	X		
McColgan and Rice (2012)		X	X	
Nicol and Young (2007)	X		X	
Ottolini et al. (2010)	X			
Paliadelis, et al. (2014)	X			
Phillips (2006)	X		X	
Sandau and Halm (2011)	X			
Schaubhut, and Gentry(2010)	X	X		
Smedley et al. (2010)	X			X
Woloschuk and Raymond (2012)		X		

Findings

Phase 2

The four provisional themes set out above were reviewed by clinical supervisors in a workshop where they critiqued the findings from their experience and expertise. A total of 36 clinical supervisors participated in three workshops: 10 in the first workshop, 11 in the second and 15 in the third.

Meaning of the literature findings for clinical supervisors

The proposed findings 'rang true' to the clinical supervisors, both in terms of their personal experiences and from what they saw and heard from colleagues. They echoed that they highly valued face-to-face learning as this enabled them to gain knowledge and skills for their role, and additionally education sessions provided a forum for networking. Online learning was viewed as supporting face-to-face education and not as a replacement. The clinical supervisors as a group reported that they often felt 'overwhelmed' by the large volume of online learning within the health service context, and this contributed to their low level of engagement with online learning for education. There was agreement in the groups when they reflected on feeling uncomfortable with scenarios or other forms of interactive simulation, such as role play, although there was a recognition that they are able to learn from having the courage the participate in this. There was discussion in the groups that although they did not like some simulation-based learning, it helped them develop sympathetic presence – an attribute of being person-centred (McCormack and McCance, 2017).

Identified gaps within the literature

Clinical supervisors identified four gaps in the provisional findings of the literature review. The first was the need to define the essential elements of an effective clinical supervisor; the second was the lack of clarity on what is required to enable effective relationships between clinical supervisors and nursing students. The third gap was an absence of focus on the responsibility of the education sector rather than the healthcare provider regarding aspects of clinical supervision. The fourth gap was a perceived lack of emphasis on the value of the role of clinical supervisors by registered nurses and the healthcare setting. The participants pointed to an absence of research or other literature exploring strategies for registered nurses who are not in a formal education role. They argued that there was a need for research in two key areas; the effectiveness of active learning (Dewing, 2009) for clinical workplace learning, and approaches to collaborative education roles between clinical supervisors and registered nurses.

Summary of clinical supervisors' key learning

During the workshops, the clinical supervisors shared their overall key learning from taking part in the research. As it is core to participatory approaches, providing learning opportunities through engagement in the research process was an overall intention in this review. The groups discussed that previously their driver to attend educational sessions had been to 'connect' or network with each other. They recognised they had always taken something away from the workshops they attended, but they had not previously knowingly appreciated the connections they made and skills they gained as having a direct impact on their practice as clinical supervisors.

Overall, there was agreement that participating in education was beneficial. Within the workshops, clinical supervisors proposed that networking at education sessions was equally as important as the content. Scenarios and methods, such as simulations and role-play, were an effective way to facilitate active learning for clinical supervisors, albeit uncomfortable. Learning from others in face-to-face environments was viewed as a positive educational strategy. Finally, blended learning approaches, such as face-to-face learning and online lesson plans, that enabled clinical supervisors to participate in workshops and then follow up online to consolidate their learning, were perceived to be beneficial. Although they saw merit in internet based learning, they also indicated that this learning is only effective if there is reliable access to the internet. This issue was a reality for the rural-based clinical supervisors in New South Wales. Unanimously, the groups agreed that there was an overdependence on online learning within healthcare, which influenced their perspective on this in regard to their own learning needs.

Discussion

First, and significantly, the findings from Phase 1 of this review indicate that participation in face-to-face education positively influences the attitudes, knowledge and skills of clinical supervisors and supports previous findings made by Phillips (2006) and Mackay et al. (2014). The findings of this small-scale review need to be considered in the context of the university setting where the research was conducted and are not intended to be generalisable (McNiff and Whitehead, 2011). The review, while rigorous, was time limited. It consisted of only 22 publications with no grey literature included. There is a degree of credibility and trustworthiness in the review findings; the fact that they rang true to local clinical supervisors lends weight to the themes and subsequent findings. In developing a person-centred curriculum, casual academic staff supporting nursing students in clinical practice are very much part of the curriculum and therefore need person-centred prerequisites, such as those set out in the person-centred framework (McCormack and McCance, 2017).

Second, this review offers some indication that the clinical supervisors valued informal, socially derived active learning as much as formal, content-based learning and this might be a topic for future research. The review suggest that, when developing educational programmes for clinical supervisors, it is worth considering the use of blended methods, consisting primarily of face-to-face sessions integrated with online education. The views of the clinical supervisors that online education is often overused should also be considered. However, there is pressure in most universities in Australia to develop online provision as it is seen as a cost-saving measure. This research would support future education programme development maintaining a component of face-to-face sessions to value the benefits associated with networking (Phillips, 2006; Bradley et al., 2007; Burns and Northcott, 2009; Ayala et al., 2014; Blum, 2014; McColgan and Rice, 2014; Browning and Pront, 2015). Since in Australia, the casual academic staff who supervise nursing students in clinical practice largely work remotely from universities and across a disparate range of geographical areas (Mackay et al., 2014), future education development and support should include opportunities to network with each other. Bringing people together for education would also provide an opportunity to consider how this authentic engagement can assist in developing communities of practice – which is consistent with a person-centred approach to developing curriculum (PcP-ICoP, 2017). Interestingly, the clinical supervisors did not critique the formal content of education programmes.

There appears to be limited evidence in the literature on the educational requirements of preparing clinical supervisors to influence the creation of person-centred learning environments. This literature review found four articles that considered positive learning environments (Davis et al., 2009; Smedley et al., 2010; Borch et al., 2013; Ford et al., 2013) but none that focused on person-centred learning culture or the specific education strategies to develop this. The clinical supervisors were not specifically directed to discuss this in the workshops as there was no related finding from the literature review. More broadly, when considering the design of person-centred curricula, it is worth considering that person-centredness has not been embedded in pre-registration nursing curriculum development, specifically in learning and teaching strategies in the clinical practice or non-classroom setting (O'Donnell et al., 2017). The complexity and dynamic environment of clinical practice often shows up curriculum change as a slow and onerous process that requires authentic cultural change (PcP-ICoP, 2017). Clinical supervisors therefore require education programmes that include critical reflection, giving and receiving feedback, and other core facilitation skills to ensure they can influence the creation of person-centred learning cultures (O'Donnell et al., 2017). Importantly, they also require an understanding of supporting nursing students through a person-centred lens, including an understanding of creating healthful relationships (McCormack and McCance, 2017).

Further, our findings indicate that to ensure that clinical supervisors' education reflects the reality of practice, a collaborative partnership between education and health service providers would be beneficial (Luhanga et al., 2010; McColgan and Rice, 2012). The clinical supervisors raised the need to differentiate the roles of registered nurses who work with nursing students in practice. In the Australian

context, the nursing student works with a registered nurse for eight hours a day, whereas, the clinical supervisor is allocated one hour a day for each nursing student. As a group, it was evident that clinical supervisors felt the buddy registered nurse spent the most time with the nursing student yet received minimal if any training or support to prepare them for this role. There are two perspectives to be considered here. The first proposes all registered nurses have a role in preparing our future workforce and that this is defined within the registered nurse standards for practice (Nursing Midwifery Board of Australia, 2016). The second perspective anecdotally discussed in clinical practice by registered nurses and somewhat validated by the clinical supervisors in this study, is that registered nurses require specific education to perform the supervisor role effectively. Thus, there is a need for further research to consider how education and support can be provided to registered nurses across a dynamic and changing workforce, and what impact this may have on developing healthful relationships and influencing person-centred learning cultures.

Finally, the significance of this participatory literature review lies in authentically engaging with the nurses whose role it is to supervise nursing students in practice. Engaging authentically is a person-centred process within the Person-centred Practice Framework (McCormack and McCance, 2017) and considered by this article's authors to be a connectedness in the moment, which draws on and into the encounter, knowledge of the person and professional expertise and energy that enables a positive encounter (Dewing and McCormack, 2015). Inherent in this context of authenticity is the belief that everyone has potential (McCormack and McCance, 2017) to learn. Facilitating authenticity within the groups demonstrated that the clinical supervisors could be true to their personal way of being in the world and could express views honestly. A noteworthy outcome of engaging authentically with this group of clinical supervisors was that they expressed feeling valued and appreciated at being asked to participate. They overwhelmingly stated that this experience would motivate them to participate in similar research in the future. Creating an environment where clinical supervisors are actively involved in researching their practice could have a positive impact on a universities' ability to influence the creation of person-centred learning cultures (PcP-ICoP, 2017). In a small way, this research has made a contribution to the body of knowledge around person-centred practice research.

The strength of this review is that the researchers had the courage to engage with clinical supervisors who are active in clinical practice with nursing students. The supervisors provided a depth to the findings and challenged the researchers to consider the reality and complexity of working with nursing students in a challenging and evolving environment, bringing a level of authenticity to the themes that emerged. In contrast, a limitation of this review was the complexity of including clinical supervisors who had not taken part in research before. A further possible limitation for this review is that the participation of the clinical supervisors was only in Phase 2; a truly participatory approach could have included them in the review of the articles and development of the themes (McNiff and Whitehead, 2011). In addition, this group of clinical supervisors may have come with a specific lens from their previous experience and this could be considered both a strength and a potential perspective bias. The final limitation was a significant variety in the methodological approaches taken and the contexts that were considered.

Conclusion

In summary, a continuous face-to-face based education approach is required to provide the support needed for clinical supervisors and to create positive learning cultures for nursing students, especially for the development of person-centredness. The review indicates that limited research evidence exists regarding the potential impact of the preparation of clinical supervisors and their ability to influence person-centred learning cultures. There is also limited research into the content required within clinical supervisor education and preparation to develop casual academic staff to understand person-centred curriculum approaches. Being true to the participatory nature of this literature review, the findings will be used to influence the university's future curriculum development and input into both clinical supervisor and registered nurse education and research.

References

Ayala, J., Ing, J., Perrault, E., Elliott, G., Letkemann, L. and Bainton, M. (2014) The potential of online learning in addressing challenges in field instructor training. *Currents: Scholarship in the Human Services.* Vol. 13. No. 1. pp 1-20. Retrieved from: tinyurl.com/Ayala-online (Last accessed 2nd June 2018).

Andrews, C. and Ford, K. (2013) Clinical facilitator learning and development needs: exploring the why, what and how. *Nurse Education in Practice.* Vol. 13. No. 5. pp 413-415. https://doi.org/10.1016/j.nepr.2013.01.002.

Beecroft, P., Hernandez, A. and Reid, D. (2008) Team preceptorships: a new approach for precepting new nurses. *Journal for Nurses in Staff Development.* Vol. 24. No. 4. pp.143-8.

Blum, C. (2014) Practicing self-care for nurses: a nursing program initiative. *The Online Journal of Issues in Nursing*. Vol. 19. No. 3. https://doi.org/10.3912/OJIN.Vol19No03Man03.

Booth, A., Papaioannou, D. and Sutton, A. (2012) *Systematic Approaches to a Successful Literature Review.* London: SAGE.

Borch, E., Athlin, E., Hov, R. and Sörensen Duppils, G. (2013) Group supervision to strengthen nurses in their preceptor role in the bachelor nursing education: perceptions before and after participation. *Nurse Education in Practice.* Vol. 13. No. 2. pp 101-105. https://doi.org/10.016/j.nepr.2012.07.009.

Bradley, C., Erice, M., Halfer, D., Jordan, K., Lebaugh, D., Opperman, C., Owen, K. and Stephen, J. (2007) The impact of a blended learning approach on instructor and learner satisfaction with preceptor education. *Journal of Nurses Staff Development*. Vol. 23. No. 4. pp 164-170. https://doi.org/10.1097/01.nnd.0000281415.97106.41.

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology.* Vol. 3. No. 2. pp 77-101. http://dx.doi.org/10.1191/1478088706qp063oa.

Browning, M. and Pront, L. (2015) Supporting nursing student supervision: an assessment of an innovative approach to supervisor support. *Nurse Education Today*. Vol. 35. No. 6. pp 740-745. https://doi.org/10.1016/j.nedt.2015.02.003.

Brunt, B. and Kopp, D.J. (2007) Impact of preceptor and orientee learning styles on satisfaction: a pilot study. *Journal for Nurses in Staff Development.* Vol. 23. No. 1. pp 36-44. https://doi.org/10.1097/00124645-200701000-00008.

Burns, H. and Northcott, T. (2009) Supporting preceptors: a three-pronged approach for success. *The Journal of Continuing Education in Nursing.* Vol. 40. No. 11. pp 509-513. https://doi.org/10.3928/00220124-20091023-08.

Cook, N. (2017) *Co-creating Person-centred Learning and Development Experiences with Student Nurses in Practice through Action Research*. PhD Thesis. Ulster University, Belfast, Northern Ireland.

Davis, B., Clevenger, C., Posnock, S., Robertson, B. and Ander, D. (2015) Teaching the teachers: faculty development in inter-professional education. *Applied Nursing Research*. Vol. 28. No. 1. pp 31-35. https://doi.org/10.1016/j.apnr.2014.03.003.

Dewing, J. (2009) Moments of movement: active learning and practice development. *Nurse Education in Practice.* Vol. 10. No. 1. pp 22-26. https://doi.org/10.1016/j.nepr.2009.02.010.

Dewing, J. and McCormack, B. (2015) Engagement: a critique of the concept and its application to person-centred care. *International Practice Development Journal.* Vol. 5. Suppl. pp 1-10. https://doi.org/10.19043/ipdj.5SP.008.

Ford, K., Courtney-Pratt, H. and Fitzgerald, M. (2013) The development and evaluation of a preceptorship program using a practice development approach. *Australian Journal of Advanced Nursing.* Vol. 30. No. 3. pp. 5-13. Retrieved from: tinyurl.com/Ford-preceptor (Last accessed 5th December 2018).

Giddens, J. and Eddy, L. (2009) A survey of physical examination skills taught in undergraduate nursing programs: are we teaching too much? *The Journal of Nursing Education.* Vol. 48. No. 1. pp 24-29. https://doi.org/10.3928/01484834-20090101-05.

Health Education and Training Institute (2013) *The Superguide: A Supervision Continuum for Nurses and Midwives*. Retreived from: tinyurl.com/HETI-superguide (Last accessed 11th November 2018).

Hill, B. (2009) Comparison of journal title coverage between CINAHL and Scopus. *Journal of the Medical Library Association*. Vol. 97. No. 4. pp 313-314. https://doi.org/10.3163/1536-5050.97.4.017.

Levett-Jones, T. and Lathlean, J. (2009) The ascent to competence conceptual framework: an outcome of a study of belongingness. *Journal of Clinical Nursing*. Vol. 18. No. 20. pp 2870-2879. https://doi.org/10.1111/j.1365-2702.2008.02593.x.

Luhanga, F., Dickieson, P. and Mossey, S. (2010) Preceptor preparation: an investment in the future generation of nurse. *International Journal of Nursing Education Scholarship*. Vol. 7. Article 38. pp 1-18. https://doi.org/10.2202/1548-923X.1940.

Mackay, M., Brown, R., Joyce-McCoach, J. and Smith, K. (2014) The development of a model of education for casual academic staff who support nursing students in practice. *Nurse Education in Practice*. Vol. 14. No. 3. pp 281-285. https://doi.org/10.1016/j.nepr.2013.08.005.

McAllister, M. and McKinnon, J. (2009) The importance of teaching and learning resilience in the health disciplines: a critical review of the literature. *Nurse Education Today*. Vol. 29. No. 4. pp. 371-379. https://doi.org/10.1016/j.nedt.2008.10.011.

McColgan, K. and Rice, C. (2012) Clinical supervision: the development of an online resources for supervisee training. *Nursing Standard*. Vol. 26. No. 24. pp. 35-39. https://doi.org/10.7748/ns2012.02.26.24.35.c8945.

McCormack, B., Dewing, J. and McCance, T. (2011) Developing person-centred care: addressing contextual challenges through practice development. *Online Journal of Issues in Nursing*. Vol. 16. No. 2. Man. 3. https://doi.org/10.3912/OJIN.Vol16No02Man03.

McCormack, B. (2012) The Person-centred Practice Research International Community of Practice: Guest editorial. *International Practice Development Journal*. Vol. 2. No. 2. pp 1-2. Retrieved from: fons.org/library/journal/volume2-issue1/guesteditorial. (Last accessed 20th July 2018).

McCormack, B. and McCance, T. (Eds.) (2017) *Person-Centred Practice in Nursing and Healthcare: Theory and Practice*. (2nd Edition). Chichester: John Wiley and Sons.

McNiff, J. and Whitehead, J. (Eds.) (2011) *All you Need to Know about Action Research*. (2nd Edition). London: SAGE.

Mezirow., J. (1978.). Perspective transformation. *Adult Education Quarterly*. Vol. 28. No. 10. pp 100-110.

National Health and Medical Research Council (2007) *National Statement on Ethical Conduct in Human Research: Updated May 2015*. Canberra: NHMRC. Retrieved from: tinyurl.com/NHMRC-conduct. (Last accessed 10th January 2019).

Nicol, P. and Young, M. (2007) Sail training: an innovative approach to graduate nurse preceptor development. *Journal for Nurses in Staff Development*. Vol. 23. No. 6. pp 298-302. https://doi.org/10.1097/01.NND.0000300838.66728.93.

Nursing Midwifery Board of Australia (NMBA) (2016) *The Registered Nursed Standards for Practice*. Retrieved from: tinyurl.com/NMBA-standards (Last accessed 11th January 2019).

O'Donnell, D., Cook, N. and Black, P. (2017) Person-centred nursing education. Chp 7 *in* McCormack, B. and McCance, T. (Eds.) (2017) *Person-centred Practice in Nursing and Healthcare: Theory and Practice*. (2nd Edition) Chichester: Wiley-Blackwell. pp 99-117.

Ottolini, M., Ozuah, P., Mirza, N. and Greenberg, L. (2010) Student perceptions of effectiveness of the eight step preceptor (ESP) model in the ambulatory setting. *Teaching and Learning in Medicine*. Vol. 22. No. 2. pp. 97-101. https://doi.org/10.1080/10401331003656454.

Paliadelis, P., Stupans, I., Parker, V., Piper, D., Gillan, P., Lea, J., Jarrott, H., Wilson, R., Hudson, J. and Fagan, A. (2014) The development and evaluation of online stories to enhance clinical learning experiences across health professions in rural Australia. *Collegian*. Vol. 22. No. 4. pp 397-403.

Phillips, R. (2006) Tools used in learning management systems: analysis of WebCT usage logs. *In* Markauskaite, L., Goodyear, M. and Reimann, P. (2006) (Eds) *The 23rd Annual Conference of the Australian Society for Computers in Learning in Tertiary Education: Who's Learning? Whose Technology?* Vol. 2. Sydney: Sydney University Press. pp 666-674. Retrieved from: tinyurl.com/Philips-WebCT (Last accessed 7th May 2019).

Sandu, K. and Halm, M. (2011) Effect of a preceptor education workshop: part 2. Qualitative results of a hospital-wide study. *Journal of Continuing Education in Nursing*. Vol. 42. No. 4. pp 172-181. https://doi.org/10.3928/00220124-20101101-02.

Schaubhut, R.and Gentry, J. (2010) Nursing preceptor workshops; partnership and collaboration between academia and practice. *Journal of Continuing Education in Nursing.* Vol. 41. No. 4. pp 161-162. https://doi.org/10.3928/00220124-20100326-01.

Seedhouse, D. (1986) *Health: The Foundations for Achievement.* California: Wiley.

Smedley, A., Morey, P. and Race, P. (2010) Enhancing the knowledge, attitudes, and skills of preceptors: an Australian perspective. *The Journal of Continuing Education in Nursing.* Vol. 41. No. 10. pp 451-461. https://doi.org/10.3928/00220124-20100601-08.

The International Community of Practice for Person-centred Practice Research (2017) *Position Statement on Person-centredness in the Curriculum.* Edinburgh: Queen Margaret University.

Torchia, J. (2008) *Exploring Personhood: An Introduction to the Philosophy of Human Nature*. Maryland: Rowman and Littlefield.

Wicks, P. and Reason, P. (2009) Initiating action research: challenges and paradoxes of opening communicative space. *Action Research.* Vol. 7. No. 3. pp 243-263. https://doi.org/10.1177/1476750309336715.

Woloschuk, D. and Raymond, C. (2012) Development and evaluation of a workplace-based preceptor training course for pharmacy practitioners. *Canadian Pharmacists Journal.* Vol. 145. No. 5. pp 231-236. https://doi.org/10.3821/145.5.cpj231.

World Health Organization (2007) *People-centred Health Care: A Policy Framework.* Geneva: WHO. Retrieved from: tinyurl.com/WHO-framework-PCH (Last accessed 10th January 2019).

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Appendix C

Guideline - Facilitating Learning between students and clinical supervisors in practice.

UNIVERSITY
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AUSTRALIA

UOW SCHOOL OF NURSING

Facilitating Learning between Students and Clinical Supervisors in practice.

Contents

1 Aim

The aim of this facilitating of learning between students and clinical supervisors in practice guideline is to inform students and clinical supervisors of the expectation of the supervision during their clinical placement within the Bachelor of Nursing Programme.

2 Objectives

This guideline has the following objectives

- Articulate the expectations for the supervision of students in practice during a clinical placement.
- Clarify the roles of registered nurses who supervise and work with students in practice.
- Outline the model of supervision for students in practice.
- Describe the 6 steps for the implementation of the model of supervision.

3 Definitions

Term	Definition
Student	The term student is used to describe persons enrolled in the Bachelor of Nursing who are undertaking a workplace experience placement as part of their degree requirements.
Clinical Supervisor	Internationally and within Australia, there is no agreed model of clinical supervision for nursing students in clinical practice. UOW SN utilises the term Clinical Supervisors to define all registered nurses in clinical practice who take on the role of the supervision and assessment of students.
Clinical Facilitator	Clinical facilitators are registered nurses who are casual academics employed by UOW and have a role in the supervision and assessment of students in practice; they are allocated on a 1:8 ratio. Clinical Facilitators in this role are generally on a set shift of either day or afternoon shift, however, this may include coverage across both shifts at times and this is called a through shift which covers 10 am to 6.30 pm. Where there are less than 8 students allocated the workload allocation is 5 hours per student per week.
Preceptor	Preceptors are registered nurses who work for our host health provider organisations and they provide the overarching supervision of students in practice. Within the preceptor model, a designated preceptor is assigned to the student for the duration of their clinical placement and assessment is generally shared between the preceptor and buddy registered nurses who work with students at the point of care. It is expected that the supervision of students is allocated to the preceptor with a workload of 5 hours per student per week. UOW SN renumerates host healthcare providers who elect to work with the preceptor model at an agreed rate for five hours per student per week. This model should not be more than 2 registered nurses in any placement period.
Clinical Liaison Facilitator	Clinical Liaison facilitators are registered nurses who work for the university and provide overarching support of students placement in practice in partnership with the health service. Within this model, the Clinical Liaison Facilitator provides support to the preceptor / registered nurses and students during a period of clinical placement. The host healthcare provider takes the responsibility for the assessment of the students' performance. This model is on a 1:16 ratio and there is no remuneration for the host healthcare providers for the supervision of students.
Buddy Registered Nurse	The buddy registered nurse is the registered nurse who works at the bedside with the student in practice for a designated shift allocation. This registered nurse negotiates their role on a daily basis with the clinical supervisor and the student. This RN may change on a shift-to-shift basis and may include a role in the assessment of students in practice.
Subject Coordinator	The subject coordinator is an academic staff member at the university who coordinates the workplace experience subject the student and clinical supervisor are enrolled/employed in.

4 Background

Students within the BN are required to undertake 840 hours of workplace experience to be eligible to register as a nurse at the completion of the degree. The School of Nursing (SN) is committed to providing high quality placements that enable students to experience a variety of areas within nursing practice. These workplace experience placements are undertaken with healthcare providers across New South Wales (NSW) and the Australian Capital Territory (ACT). The SN also provides students with the opportunity to have bespoke opportunities with interstate and international health service providers by expression of interest.

Students are expected to navigate a broad range of workplace experience placements and integrated within their preparation for practice they are challenged to consider person-centredness and their role in influencing the creation of healthful cultures within the services where they undertake placement (McCormack and McCance 2017). Healthful cultures in this context focus on wellbeing for all involved in the care process and the measurement of this as an outcome from all perspectives, creating the capacity to change how people, carers and health professionals influence and experience care (McCormack and McCance 2017). This concept of healthfulness is inclusive of all staff who are involved in the delivery of care and challenges students to consider the role and value of the person receiving care, their carers and the interdisciplinary team. Students are required within their ANSAT assessment (Standards 2.7-2.9) to understand the role of the nurse as well as the nurse's collaboration and engagement with other health care professions. Through these workplace experience placements, students gain a deeper understanding of the health care team and the disciplines which combine to deliver individualised care. This clinical exposure to these interdisciplinary components and activities is underpinned by the interdisciplinary learning which takes place in subjects throughout the Bachelor of Nursing.

The curriculum for the Bachelor of Nursing has been designed to ensure that students' workplace experience is an independent subject and students are not undertaking other subjects at the same time. Within each session, students will undertake three subjects that combine online lectures, laboratories/simulations and tutorials that are designed to prepare students for their workplace experience placement and to assist in the application of theory prior to their placement. In responding to concerns raised by students in the current program, the design of the curriculum ensures that there are no assessments due while students are on workplace experience. This allows students to focus fully on their placement experience and minimises the distractions of competing demands.

Students within the Bachelor of Nursing will be provided with a variety of workplace experience placements across their degree. Each student will undertake 840 hours of placement prior to the completion of their degree. This will be distributed across the three years of the degree as below:

- 1st year – 160 hours
- 2nd year – 320 hours
- 3rd year – 360 hours.

In accordance with the NMBA Accreditation Standards (2019), students enrolled in a degree that leads to registration as a nurse are required to undertake a variety of placements. To ensure students have exposure to the reality of nursing practice and a variety of areas of clinical practice, their placement allocations will be mapped within SONIA (the electronic placement system used by UOW). This mapping will ensure all students complete the requirements of a workplace experience placement in a range of settings. These settings may include aged care, mental health nursing, primary and community nursing, acute care nursing (adult and paediatric) and critical care nursing.

5 Model of Supervision

The School of Nursing, Bachelor of Nursing curriculum is developed within constructivist learning theory. This is not one pedagogy rather it includes a wide ranging impact on learning theories. Constructivist learning approaches are embedded within active learning where clinical supervisors and students learn together and this learning is constructed from their experiences in the clinical environment. Within a constructivist learning approach, clinical supervisors have a role in the facilitation of student learning enabling them to be experts in their own learning and bring together their learning from the classroom based subject to inform the development of new knowledge in clinical practice.

In determining the key elements for clinical supervision, 110 clinical supervisors participated in a creative exercise. The outcome from this was the development of the tagxedo, which is at the beginning of this guideline in the shape of a key and which highlights the keywords the clinical supervisors believe should be included within our model of supervision.

To ensure we are true to the clinical supervisors' vision of respecting individuality and diversity within students and ensuring a positive learning experience, three key philosophical models underpin the model of supervision: the Person-Centred Practice Framework (see appendix 4 – Person-centred framework) (McCormack and McCance 2017), solution-focused nursing (McAllister 2003) and Facilitation on the Run (FoR) (Hardiman &Dewing 2014; Hardiman &Dewing 2019).
The model of supervision for students in workplace experience is underpinned by the Person-Centred Nursing Framework (McCormack and McCance 2017). Person-centredness within the framework is underpinned by the principles of human freedom, choice and responsibility, holism, different forms of knowing and the importance of time, space and relationship.

The definition of person-centredness has been broadened to consider humanising healthcare by McCormack and McCance (2017, p. 3) as:

> … an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by the values of respect for persons, individual rights to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development.

Healthful relationships in this context are evident when decision making is shared, staff relationships are collaborative, leadership is transformative and innovative practices are supported. They are attributed as the ultimate outcome in developing workplace cultures that are person-centred (McCormack and McCance 2017, p.60).

The understanding of healthful relationships between students and their clinical supervisors in practice has been part of Maria Mackay's PhD (2020) research where she explored how healthful relationships influence transformational learning in practice. The discoveries of this research have found that knowing self to enable belonging and respecting personhood are fundamental to the creation of healthful relationships. The ultimate outcome of crafting healthful relationships is that they are evident when persons experience a sense of being in practice together whilst seeking each other to reach their full potential. There are five Healthful ways of being that are outlined in the model below. The definition of this these are in appendix 7.

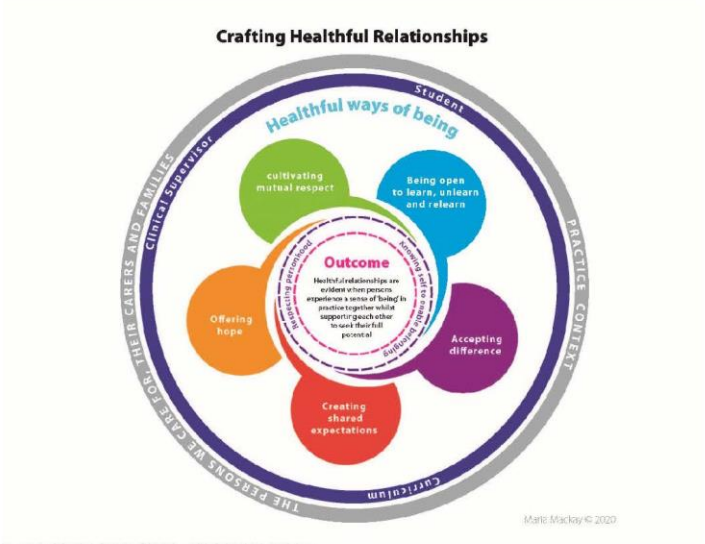


Image: Model for crafting healthful relationships

Solution-focused nursing adds to person-centredness and provides the platform for working in strength based ways with students. This model comes from the perspective where clinical supervisors work with students through authentic engagement and consider them as the expert in their educational journey (McAllister 2003). Underpinning principles of solution-focused nursing is that the focus is on the person rather than the problem,

language is hopeful and future focused, and issues identified are seen as temporary. Believing that people have the capacity to change to improve and that small change can bring about a profound difference is a fundamental premise of this model. McAllister (2005) argues that solution-focused ways of working are supported by transformational learning. Within this context transformational learning includes seeing and doing in effective ways, noticing the overlooked, seeing strengths and possibilities and acting with (not for) people.

FoR (Hardiman &Dewing 2014; Hardiman &Dewing 2019) is underpinned by the person-centred practice framework and incorporates principles of solution-focused nursing in that it emphasises identifying strengths and valuing the person as an expert in their learning. The FoR model has been developed as 'stepping stones' for the development of facilitation skills from a novice to an expert critical companion. There are two key models within this. They are Critical Allies and Critical Friends (see appendixes 5 and 6). Significantly, clinical supervisors and nursing students need to work together collaboratively and determine the level of their relationship through consideration of how to establish the pre-requisites that are outlined in the framework. Pre-requisites are described for each of the models and are concepts that a facilitator of learning should focus on to ensure they have the groundwork in place to create an intentional relationship. Once the pre-requisites have been established the model provides guidance for the appropriate strategies that will bring about person-centred outcomes and assist in developing healthful relationships between students and their clinical supervisor.

6 Guidelines

The UOW SN has a 6-stage process for supporting students in practice. The application of this model needs to reflect the principles of our model for supervision, person-centredness, solution focussed ways of working and FoR. The following headings outline the process with information that should be considered, this is not an exhaustive list rather a guideline for good practice when working with students in clinical practice.

6.1 Crafting healthful relationships

The process of crafting healthful relationships is a continual process that starts as students and clinical supervisors prepare for creating a relationship in the context of practice and which follows throughout the placement period. In the knowing or learning phase of person-centred transformational learning, students and clinical supervisors should be prepared to consider knowing self from the person-centred practice framework (McCormack and McCance 2017) from the perspective of their values and belief. They should also be challenged to accept difference and respect individual personhood. Consideration of creating healthful relationships also requires students and clinical supervisors to be exposed to emotional literacy skills and be challenged to consider their reactions and responses to difference. In the reality of practice, critical reflection and critical dialogue provide the conduit for learning to take place in the turbulence of practice and for this learning to be transformed into purposeful turbulence where learning occurs.

6.2 Meet and Check in process

There is no requirement for students and clinical supervisors to contact placement facilities prior to the commencement of the placement. Day 1 instructions are outlined in the facility information linked within SONIA for students and UOW Clinical Facilitators. For preceptored placements, students will follow the instructions provided by each organisation for day 1. The provision of orientation is the responsibility of the health provider. Clinical Supervisors are responsible for ensuring students receive orientation at the commencement of their clinical placement or as soon as possible on Day 1 of the placement. It is expected that the clinical supervisor will be present at the orientation process for students.

Within the check in process, it is expected that students and supervisors establish the pre-requisites of their facilitative relationship. Consider the establishment of critical allies (Hardiman &Dewing 2014; Hardiman &Dewing 2019), mutual respect, shared values, preparedness and authentic presence as a minimum. Healthful relationships are to be explored in terms of acknowledging shared leadership and joint responsibility to learn from each other. Students should commence a conversation with their clinical supervisor where they will share their values, feelings and expectations as a way of establishing ways of working (see appendix 1 – student led conversation form). It is important to undertake conversations that cultivate trust and respect by being authentic and inclusive of individuality.

The initial conversation should include a strengths based approach to the self-assessment of where the student identifies their strengths and their opportunities for improvement against the NMBA (2016) RN Standards for Practice. Following this conversation, the setting of individual learning objectives for the student should be

considered from identified strengths and opportunities for improvement. Students should be encouraged to identify a learning outcome they would like to address and document this on the Student Performance Improvement Plan form (see appendix 2 – Student Performance Improvement Plan), which enables students to develop strategies to address this issue that are measurable and assist the student to meet their individual learning requirements.

The health provider should provide students an orientation to the ward or service prior to them being allocated to care for people.

6.3 Daily interaction and supervision

The daily interaction with students and clinical supervisors should include a conversation with the registered nurses they are working with and the student. Students should have the opportunity to identify their goals for the day with their clinical supervisor and buddy RN. Conversations should include critical questions and seeking examples of practice to explore. It takes courage to provide honest feedback and conversations with both registered nurses and student's needs to enable the opportunity to provide honest feedback and comments. The conversations should respect the personhood of others and seek to see the person behind the title.

Clinical supervisors should role model and articulate person-centred practice. Using gentle language with consideration of both tone and body language is encouraged. The focus of the strategies that clinical supervisors implement in daily interactions and supervision should be on achieving the outcomes of the FoR and person-centred frameworks. Consideration should be given to ensuring the pre-requisites of the critical allies and critical friends are still in place or if they need to be revisited. The strategies for the FoR (2017) model that best suit the relationship should be agreed to by the clinical supervisor and the student. The daily interactions should support challenging what is known about oneself to enable persons to have the courage to be authentic in their actions and behaviours.

Daily conversations should include a strengths based approach to the self-assessment of where the student identifies their strengths and their opportunities for improvement are against the NMBA (2016) RN Standards for Practice. A review of the student's individual learning objectives should be included in the daily review of how the student is progressing. Any issues identified are to be raised with the Subject Coordinator as soon as identified and the subject coordinator is to be seen as an internal stakeholder in supporting students to be successful within their placement

Formal feedback is to occur using the ANSAT assessment documentation at the midpoint and end of each placement period. Person-centred feedback should be given using a strengths based approach. Issues must be raised prior to the formative or final assessment with the student in consultation with the Subject Coordinator if they are to be included within any assessment.

6.4 In the moment feedback

In the moment feedback should be provided on a daily basis in the clinical setting. It is important to provide feedback in strengths based ways that enable the student to lead the conversation and explore their strengths and opportunities for improvement. Examples of practice should be used to support feedback. Clinical supervisors should ensure they provide critical feedback that identifies where the student is performing well and their opportunities for improvement against the NMBA (2016) RN Standards for Practice. We would encourage both students and clinical supervisors to have a voice in providing in the moment feedback.

This feedback should be given with gentle language that is hopeful, future focussed and suggests the problems identified are temporary. In the moment feedback should foster creating relationships that are vulnerable and brave and encourage persons to optimise difference.

6.5 Critical Conversations

Individual critical conversations should form part of the daily supervision and conversation between the clinical supervisor and student in a private location. The conversation should encourage the student to think out loud and identify strategies that will enable them to develop a deeper understanding of themselves, the nursing profession and the specialist area of practice they are currently experiencing. Critical conversations should be ensconced in a way that enables both students and clinical supervisors to have a learning (asking) lens rather

than an expert (telling) lens. The use of enabling questioning (see appendix 3 – enabling framework questions) is encouraged to explore the issues raised.

Whare concerns are raised regarding the students ability to meet the required level of knowledge and skills in their placement, feedback should is to be documented in consultation with the clinical supervisor using the Student Performance Improvement Plan. This form should enable the student to identify their own strategies for improvement.

Any concerning issues identified are to be raised with the Subject Coordinator as soon as identified and the Subject Coordinator is to be seen as an internal stakeholder in supporting students to be successful within their placement. This feedback should be documented as above and in consultation with the Subject Coordinator using the Student Performance Improvement Plan.

6.6 Group debriefing

Group debriefing can only occur in placements where multiple students attend and should include a group of students meeting to explore practice issues and assist each other to develop solutions that are specific to the context of the care environment and that inform their future practice. These group debriefing sessions form an integral part of the facilitation of student learning in clinical practice. The timing of these sessions need to be negotiated with the wards/services and should be at least once per week. Students from a variety of years should be encouraged to attend. Importantly, in group debriefing students and clinical supervisors need to encourage each other to move towards discomfort by co-creating shared ways of doing and being with each other.

The process should use the enabling framework of clarifying, reflecting, challenge and probing, and action. Time should be spent creating a safe space for students to share their practice experiences. Each student should identify a challenge they have faced within practice, and as a group reaches an agreement as to which practice example will be utilised and explored. Students should lead the enabling framework being enacted. The observer should provide feedback and ensure that the conversation follows the enabling framework and that the student remains safe within the space. Once the conversation reaches a natural closure, a process check should be completed and the student who was responding should have the opportunity to provide feedback on how the experience was for them.

6.7 Check out and completion of placement

Towards the end of the placement, students should receive all of the paperwork required. Students are responsible for ensuring all of their requirements have been met and all of their assessments are completed and signed. Clinical Supervisors are responsible to complete all required paperwork and to communicate honestly with the student regarding the placement experience. Reflection on the placement and relationship between the students and clinical supervisor should be a daily practice that includes contemplation of what went well and any challenges.

Students and Clinical Supervisors must have a conversation to conclude the placement. This should include both the student and clinical supervisor having the opportunity to provide feedback on the overall placement, how it felt and what their experience was. This conversation should be in a safe place where both parties have the opportunity to be courageous and honest in sharing their experiences. The conversation should start with what worked well and then progress to any challenges and barriers. Any issues raised that are not able to be resolved by either party should be referred to the Subject Coordinator for consideration and support. Checking out includes a conversation on the supervisory relationship that is open and honest, A place to start is considering that a healthful relationship is evident when persons experience a sense of being in practice together whilst supporting each other to seek their full potential. Consider if this was evident for you.

7 References

Hardiman, M., & Dewing, J. (2014). Critical ally and critical friends: Stepping stones to facilitating practice development. *International Journal of Practice Development*, 4(1), 1-19. Retrieved from https://www.fons.org/Resources/Documents/Journal/Vol4No1/IPDJ_0401_03.pdf

Hardiman, M., & Dewing, J. (2019). Using two models of workplace facilitation to create conditions for development of a person-centred culture: A participatory action research study. *Journal of Clinical Nursing*, doi:10.1111/jocn.14897.

McAllister, M. (2003). Doing practice differently: Solution-focused nursing. *Journal of Advanced Nursing*, 41(6), 528-535. doi:10.1046/j.1365-2648.2003.02564.x.

McAllister, M. (2005). Transformative teaching in nursing education: Leading by example. *Collegian*, 12(2), 11-16, doi:1016/S1322-7696(08)60487-4.

McCormack, B & McCance. T (eds). (2017). *Person-Centred Practice in Nursing and Health Care: Theory and Practice*. United States: John Wiley & Sons.

Nursing and Midwifery Board of Australia. (2019). *Registered Nurse Standards for Practice*, Retrieved from http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/registered-nurse-standards-for-practice.aspx .

Nursing and Midwifery Board of Australia. (2019). *Registered Nurse Accreditation Standards*, Retrieved from https://www.anmac.org.au/sites/default/files/documents/registerednurseaccreditationstandards2019.pdf.

8 Version Control Table

Version	Release Date	Author/Reviewer	Approved By	Amendment
1	09/04/2018	Maria Mackay Director of Clinical Learning Carley Jans Deputy Director of Clinical Learning	Full name & title	Initial version.
2	02/06/2019	Maria Mackay Director of Clinical Learning	Maria Mackay	Revision 1
3	15/10/2020	Maria Mackay Director of Work Integrated Learning Carley Jans Lecturer Dr Sharon Bourgeois		Revision 2

Appendix 1 – STUDENT LED CONVERSATION: Establishing ways of working between nursing students and clinical supervisors

This page has intentionally been placed at the beginning of the assessment in practice document to provide you the nursing student, with an outline to introduce yourself to your clinical supervisors. Most important, is that you have the opportunity to share your values, how you are feeling about this placement and establish ways of working with your clinical supervisor. Clinical supervisors can reciprocate and introduce themselves to you too. This is intended to be part of a conversation led by you, the nursing student.

In starting the conversation it is expected that the clinical supervisor provides time to sit quietly with the nursing students either individually or as a group and allows the nursing student to start the conversation and share with you their values, feeling and expectations. This conversation should occur on **Day 1** of the placement.

Suggested way to start the conversation

> *As part of the requirements for my placement it would be really helpful to me for us to have a conversation about my values and how I am feeling about my placement.*
>
> *I would really appreciate if we could spend a few minutes going over this form as it will guide us both through a process of sharing our thoughts about nursing and working with people in clinical practice.*

Hello, My Name is _____

I value the following when I am in the role of a nurse caring for people in practice

- _____
- _____
- _____
- _____

I have the following feelings about this workplace experience placement

- _____
- _____
- _____
- _____

I have the following expectations of my experience of clinical supervision during this workplace experience placement

- _____
- _____
- _____
- _____

Could you please share with me your expectations of me as a nursing student during this workplace experience placement?

- _____
- _____
- _____
- _____

The following are our agreed ways of working together

- _____
- _____
- _____
- _____

Appendix 2 – Student Performance Improvement Plan

The focus of this Performance Improvement Plan is to provide a process for both students and their clinical supervisors to identify areas of improvement and work together using strengths based strategies.

Ideally, this form is to be completed by the student and to be discussed with their clinical supervisor. Alternatively, clinical supervisors (in consultation with the subject coordinator) can complete if an identified issues arises.

All conversations should indicate clearly what the issue is, allow for time and reflection to identify appropriate strategies for improvement and consider that the language used should be hopeful, future focused and consider the issue identified to be temporary.

Date _____

Student Name_____**Student Number:** _____

Student rating /10 **Facilitator rating** /10

Rating required at end of placement /10

Issue _

_____

_____

Agreed strategies for improvement (*this section must be Student led)*

_____

_____

_____

_____

_____

_____

_____

_____

Follow up Discussion *(to be completed no later than 3 days after the initial discussion and development of agreed strategies)*

_____

_____

_____

_____

_____

_____

_____

_____

_____

Has the issue been resolved (yes / no)

If no to repeat the process until the issue is resolved.

Any concerns regarding this process should be referred to the Subject Coordinator

Appendix 3 – Enabling Framework Questions

CLARIFYING QUESTIONS

These assist to get a clear picture of facts and the issue being explored.
They are generally open-ended, although structured closed questions can be used to provide focus.

Tell me what you did?

What thoughts were you having at the time?

What did you do next?

What did that mean to the process?

Is there a theme in this?

It sounds like... is that the case?

Is it fair to say that...?

REFLECTING QUESTIONS

These are designed to promote deeper levels of reflection (reference) so that new perspectives can be revealed, patterns of responses identified, and understanding enhanced.

Have you had a similar experience in the past?

What have you done in the past in a similar situation?

What were people around you doing at the time?

What have you learnt from this?

What are your normal responses to this kind of situation?

What have you seen other people do in this situation?

PROBING & CHALLENGING QUESTIONS

Questions of this type are directed towards opening up potential through supported challenge.

What would you do differently in the future in a similar situation?

In an ideal situation what would be different?

What are you thinking right now?

Adapted from SESLHD - Enabling Framework Questions

What are you feeling about the current situation?

What is the evidence to support you?

What part of this have you not explored yet?

What are you contributing to this by your actions or inactions?

What would support look like to you?

ACTION QUESTIONS

These are important to ensure that active learning is facilitated through carrying out plans.

What supports are available to you?

What support will you need and from whom?

What are your options in moving ahead?

What advice would you give someone else in this situation?

How committed are you to doing this?

Who are the stakeholders in this?

What specific actions will you take?

What is your first action to resolve this?

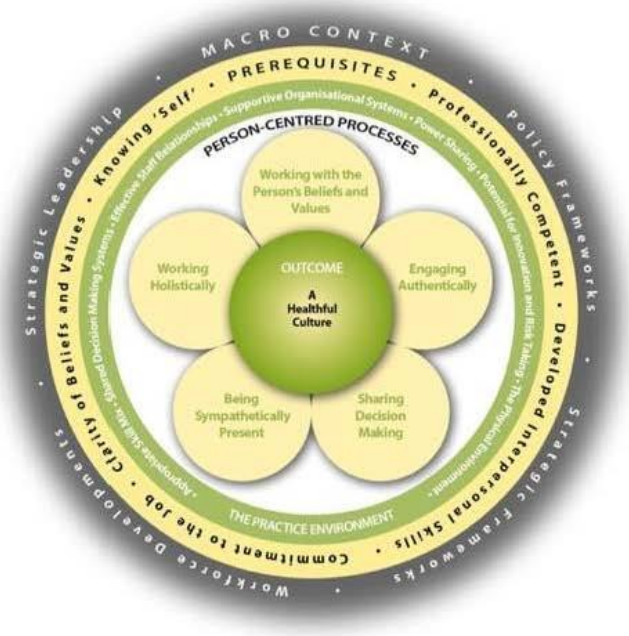
How will you measure success?

NSW GOVERNMENT | Health
South Eastern Sydney
Local Health District

Adapted from SESLHD - Enabling Framework Questions

Person-centred Practice Framework

(McCormack &McCance (2018 revised)



1

DEFINITION

DEFINITIONS OF THE CONSTRUCTS

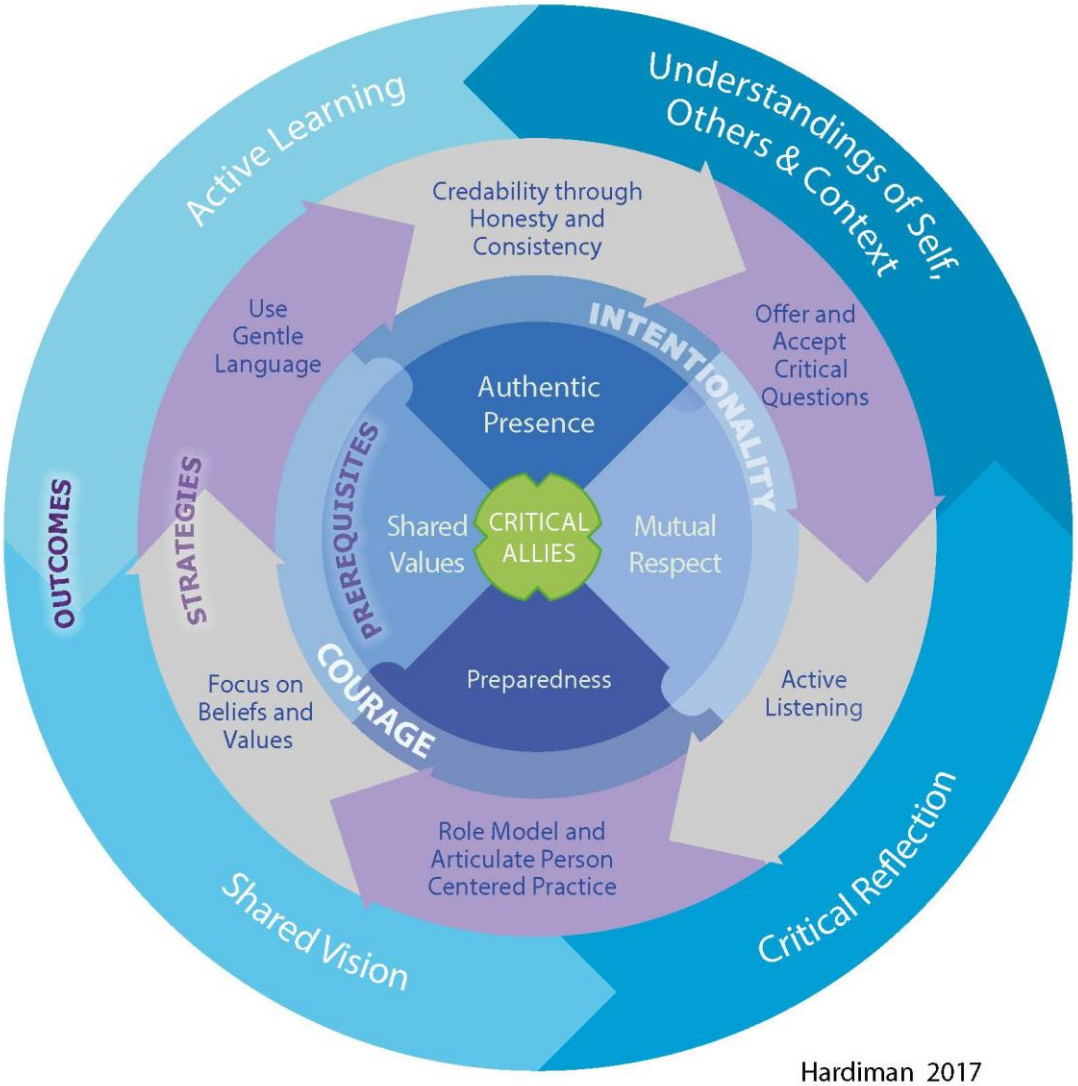
Macro-context	
Health and social care policy	*International, national and local policies influencing the development of person-centred cultures.*
Strategic frameworks	*International, national and local frameworks with a vision, mission and time frames to guide the development and evaluation of person-centred cultures*
Workforce developments	*International, national and local models and frameworks that guide the development and sustainability of staffing models as well as learning and support systems for person-centred cultures.*
Strategic leadership	*Engagement of key stakeholders in the development, implementation and sustainability of strategies for person-centred cultures.*
Prerequisites	
Professionally competent	*The knowledge, skills and attitudes of the practitioner to negotiate care options, and effectively provide holistic care.*
Developed interpersonal skills	*The ability of the practitioner to communicate at a variety of levels with others, using effective verbal and non-verbal interactions that show personal concern for their situation and a commitment to finding mutual solutions.*
Knowing self	*The way an individual makes sense of his/her knowing, being and becoming as a person-centred practitioner through reflection, self-awareness, and engagement with others.*
Clarity of beliefs and values	*Awareness of the impact of beliefs and values on care provided by practitioners/ received by service users and the commitment to reconciling beliefs and values in ways that facilitate person-centeredness.*
Commitment to the job	*Demonstrated commitment of individuals and team members to patients, families and communities through intentional engagement that focuses on providing holistic evidence-informed care.*
Care Environment	
Appropriate skill mix	*Skill mix is most often considered from a nursing context and means the ratio of registered nurses (RNs) and non-registered nurses in a ward/unit nursing team. In a multidisciplinary context it means the range of staff with the requisite knowledge and skills needed to provide a quality service.*
Shared decision-making systems	*Organizational commitment to collaborative, inclusive and participative ways of engaging within and between teams.*
Effective staff relationships	*Interpersonal connections that are productive in the achievement of holistic person-centred care.*
Power sharing	*Non-dominant, non-hierarchical relationships that do not exploit individuals, but instead are concerned with achieving the best mutually agreed outcomes through agreed values, goals, wishes and desires.*
The physical environment	*Healthcare environments that balance aesthetics with function by paying attention to design, dignity, privacy, sanctuary, choice/control, safety, and universal access with the intention of improving patient, family and staff operational performance and outcomes (adapted from HfH 2008).*

2

Supportive organisational systems	*Organisational systems that promote, initiative, creativity, freedom and safety of persons, underpinned by a governance framework that emphasises culture, relationships, values, communication, professional autonomy, and accountability.*
Potential for innovation and risk taking	*The exercising of professional accountability in decision-making that reflects a balance between the best available evidence, professional judgement, local information, and patient/family preferences.*
Person-centred Processes	
Working with patient's beliefs and values	*Having a clear picture of what the patient values about his/her life and how he/she makes sense of what is happening from their individual perspective, psychosocial context and social role.*
Sharing decision making	*The facilitation of involvement in decision-making by patients and others significant to them by considering values, experiences, concerns and future aspirations.*
Engaging authentically	*The connectedness of the practitioner with a patient and others significant to them, determined by knowledge of the person, clarity of beliefs and values, knowledge of self and professional expertise.*
Being sympathetically present	*An engagement that recognises the uniqueness and value of the individual, by appropriately responding to cues that maximise coping resources through the recognition of important agendas in their life.*
Providing holistic care	*The provision of treatment and care that pays attention to the whole person through the integration of physiological, psychological, sociocultural, developmental and spiritual dimensions of persons.*
Person-centred Outcomes	
Good care experiences	*Positive service user and staff experiences of "what was expected as well as what actually happened" (objective facts and their subjective views) during the course of receiving/delivering care and treatment.*
Involvement in care	*Services user and staff actively participate in care and engage others as needed*
Feeling of well-being	*Service users and staff are happy with their care experience and feel engaged in a meaningful way.*
A healthful culture	*Service users and staff experience a workplace culture that fosters person-centeredness and flourishing for all.*

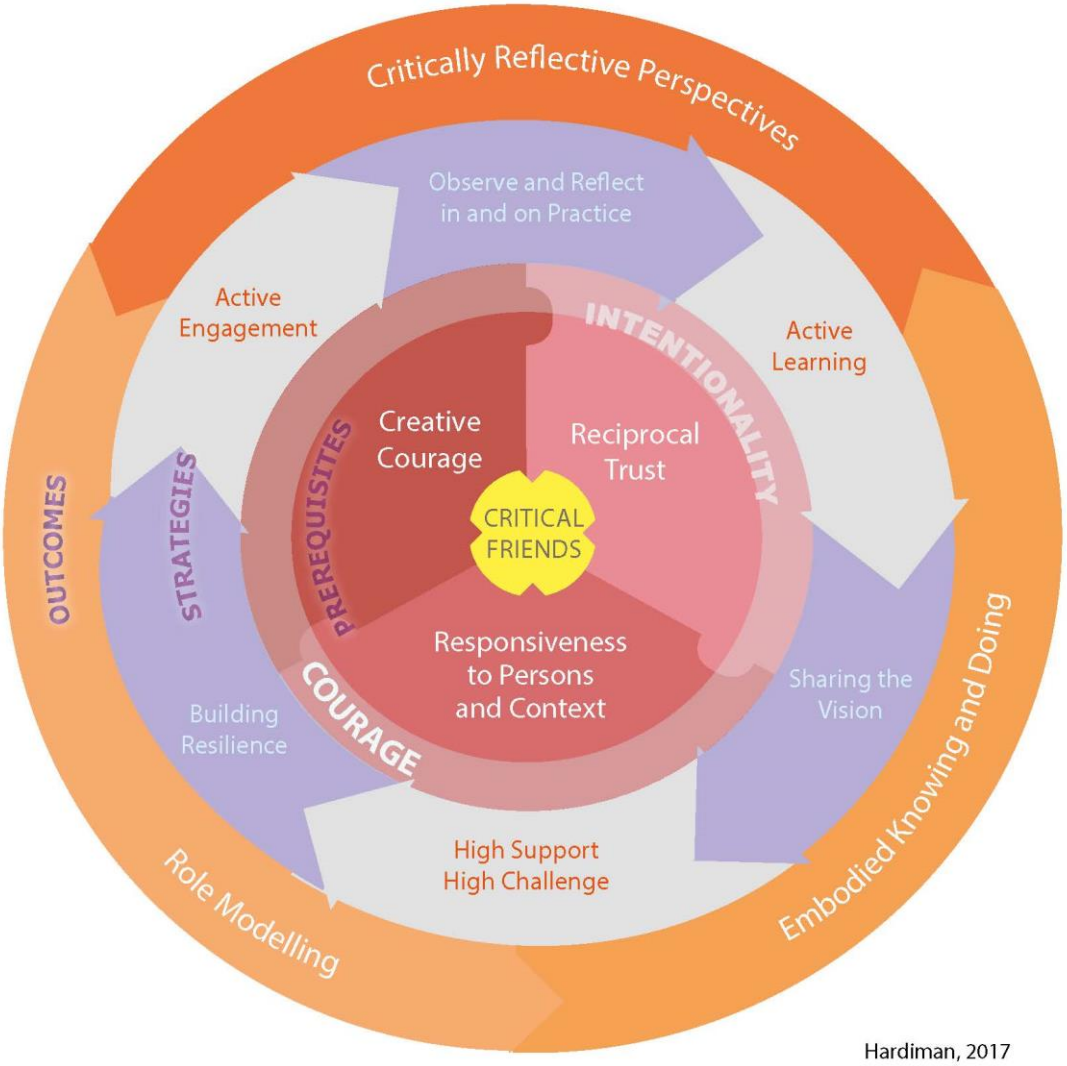
3

CRITICAL ALLIES



Hardiman 2017

CRITICAL FRIENDS



Hardiman, 2017

Crafting Healthful Relationships

	Description
The practice context	The context in which healthcare is experienced.
The persons we care for, their carers and families	Creating relationships that are inclusive and where diversity is acknowledged and respected.
Clinical Supervisor, student	Acknowledging shared leadership and responsibility to learn from each other within the practice context
Curriculum	Creating curricula underpinned with person-centred transformational learning
Enabling True-belonging	Creating relationships that challenge what is known about oneself to enable persons to have the courage to be authentic in their actions and behaviours
Respecting personhood	Creating relationships that see the person behind the title
Cultivating mutual respect	Creating relationships that cultivate trust and respect by being authentic and inclusive of individuality
Being open to learn, unlearn and relearn	Create relationships where persons have a learner rather than an expert lens
Accepting difference	Creating relationships that are vulnerable and brave and encourage persons to optimise difference
Creating shared expectations	Create relationships that move toward discomfort by co-creating shared ways of doing and being with each other
Offering hope	Create relationships where opportunities are experienced as a gift and language is hopeful, future focused and suggests issues are temporary

Appendix D

Publication – Enabling nursing students to participate in designing an educational resource to support their participation in clinical practice.

Title Page

Title

Enabling nursing students to participate in designing an educational resource to support their participation within clinical practice.

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Declarations of Conflict of Inter Interest

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Abstract

Current literature is silent regarding nursing students more effectively participating in the development of learning resources that prepare them for the reality of practice during a clinical placement. This participatory action research study aimed to explore the experiences of first year nursing students who were enabled to be active participants in the development of learning and teaching resources that supports their participation within a clinical placement. There were three findings reported by students, firstly, the students contributed to defining a healthful (supervisory) relationship (including emotional connection and vulnerability); secondly, that emotional preparation for clinical practice was required for nursing students to be prepared for the reality of clinical practice and thirdly, the students gained confidence through their participation in curriculum design and development. In conclusion, this research study demonstrates that nursing students feel empowered and have more confidence in their ability when given the opportunity to share their values, fears and expectations with their clinical supervisors. Further, participants felt they were seen as a person rather than a student in their interactions where they initiated and led a start-up conversation with their supervisors.

Key Words

Student-led, supervision, person-centred curricula, emotional preparation, clinical placement

Introduction

The research study presented in this paper is one part of a larger PhD research project. The study aimed to explore the experience of first year nursing students who were enabled to be active participants in the development of learning and teaching resources in preparation for their clinical placement. The participatory action research study was completed within a metropolitan university in NSW Australia. Nursing students at the university where this study was located undertake 840 hours of clinical placement within their Bachelor of Nursing degree. In accordance with accreditation requirements, this clinical placement must be supervised and assessed by a registered nurse who is referred to as a clinical supervisor (Australian Nursing and Midwifery Accreditation Council [ANMAC], 2012). Within the School of Nursing where the research took place, our team diligently ensured that clinical supervisors were educated and prepared for the clinical placement assessment and feedback of nursing students. However, it was raised that we do not provide the same education to nursing students. This led to several questions about teaching and learning practice and the philosophical underpinning of the curriculum. Preparing nursing students to fulfill an active role in assessment and feedback of their clinical practice is currently not included within learning and teaching strategies. Exploring this from a 'critical' theory perspective (Habermas, 1987), it can be argued that there is an imbalance of knowledge and power that may inadvertently disadvantage and even disempower nursing students. Nursing students are likely to feel more motivated and empowered, and to focus on the assessment process, if they understand more about the assessment itself and their role within assessment in practice. This equates to learning about how to learn and can provide students with higher order knowledge that may contribute to feelings of enlightenment and empowerment. Further, from a person-centred perspective, a healthful relationship, as described by McCormack &McCance (2017), between nursing students and their clinical supervisor is critical to a person-centred learning

experience and must be embedded in a healthful culture. Healthful cultures in this context are cultures where decision-making is shared, staff [and student] relationships are collaborative, leadership is transformative and innovative practices are supported (McCormack & McCance, 2017, p.60).

Background

The current literature suggests there is a lack of evidence about student participation in the development of learning and teaching resources for their preparation to participate in clinical practice. Our review in this project confirmed this position. There were a few exceptions. For example, Grace and O'Neil's developed online resources (2014; 2016) that enable students from a range of healthcare professions to interact with their supervisors in a virtual space. Other examples are of pre-placement preparation programs, including a semester long preparation for practice course for nursing students (Levett-Jones et al., 2015), a week long preparation workshop for dietetics students (Ross et al., 2017) and a four-week preparation program for occupational therapy students (Spoliotopoulou, 2007). None of these accounts report if or how the students themselves were involved in the development of the resource. Rather, the literature has focused on calls for clarification about clinical placement expectations (Levett-Jones et al., 2015; Spoliotopoulou, 2007), marking criteria (Spoliotopoulou, 2007), and clarification of language used in competence assessment documents (Helminen et al., 2014). The timing of preparation is also discussed. Bradshaw et al. (2012) argue that preparation for students is not prioritised early in their programs, as it is considered they have enough to cope with prior to their first placement along with a lack of context to relate pre-placement information. Alternatively, Grace & O'Neil (2014) implemented their preparation intervention with later stage students (3rd and 4th years) and consequently, it was argued by the student participants that the information was less relevant

to later placement experiences, as by then they are more familiar with placement processes and environments. In another study, Barrington et al. (2009) chose to implement learning contracts in semester two, as at this stage, students had completed semester one and successfully achieved learning objectives. No research appears to have taken place with first year students where preparation for practice could be embedded as learning from the beginning of their degree.

The evidence we explored does emphasise the need for preparation of both students and clinical supervisors for the competency assessment process (Bradshaw et al., 2012). Further, Bradshaw et al. (2012) recommend refreshing students' preparedness for competency assessment as competency expectations increase and, based on their research, have implemented annual orientation workshops for students. Consequently, preparation is largely approached in a mechanistic way, and it is silent in regard to the emotional preparedness of students. While student accounts of empowerment and disempowerment on clinical placements have been reported (Bradbury-Jones et al., 2007), what appears to be lacking from the literature are specific accounts of student empowerment specific to clinical assessment processes. Alongside the lack of evidence, there have been multiple calls for student-centred assessment approaches that are built on adult learning principles (Bradshaw et al., 2012; Levett-Jones et al., 2015). This perhaps suggests that the classroom assessment process is valued more highly than the clinical practice one. It could also infer that it is more challenging to respond to clinical assessment as the practice context is less understood by educationalists as it is at a distance to the university and is not directly managed by them.

Further, student empowerment is discussed in the context of it being directly influenced by three factors; negotiating learning opportunities, being able to use existing skills, and being

able to use initiative. All three of these factors are said to be enabled by clinical supervisors understanding student capabilities and monitoring student progress (Bradbury-Jones et al., 2007). Therefore, effective supervision with continuity is argued to contribute to student empowerment in clinical placements. Lack of support during clinical placements or witnessing bad practice were factors identified as attributing to both the disempowerment of nursing students (Bradbury-Jones et al., 2007) and student nurse attrition (Eick et al., 2012). Further to the application of adult learning principles in assessment, the negotiation of learning plans are reported to enable more personalised student learning, self-reflection, open communication, mutual respect, student ownership, and a shift in power from faculty to the student (Barrington & Street, 2009; Bailey & Tuohy, 2009). However, none of the literature considered the impact on the relationship between students and their clinical supervisors of students reporting experiences of empowerment within their clinical placement. Person-centred teaching and learning strategies focus on providing nursing students with the knowledge and skills they will need to contribute to creating healthful cultures in clinical practice (McCormack and Dewing 2019). Yet, many nursing students find the challenge of clinical placements very stressful and challenging (O'Mara et al., 2014). It is certainly acknowledged in the literature that students preparing to undertake clinical placements can experience degrees of anxiety and stress, which can impact on their performance (Levett-Jones et al., 2015; Ross et al., 2017; Stunden et al., 2015). Structured preparation may help to relieve anxiety and stress by addressing expectations about placements, offer coping interventions such as mindfulness techniques and other stress reduction and coping strategies, as well as suggesting methods for working with staff who are less person-centred (Levett-Jones et al., 2015; Spoliotopoulou, 2007). Such strategies may also help with preparing nursing students for placement assessment processes.

Overall, the literature was dominated by the voices of nurse educationalists and the voices of student nurses were either a minor consideration or absent. The literature influenced the intent of this research study which was completed with first year Bachelor of Nursing students. Together, we considered the question of 'How does the collaborative development of a learning resource enable nursing students to be active participants in their clinical placement?' The two objectives of this research were to provide nursing students with processes and tools to be active participants in their assessment and feedback and address some of the power imbalance that exists between nursing students and clinical supervisors. The university where this research study was completed is in the process of implementing a revised person-centred nursing curriculum, much as described by McCormack and Dewing (2019) and therefore it was timely to consider the student participation and voice in their preparation for clinical practice and ultimately their future as person-centred practitioners.

Participants

Participants were first year nursing students who have already completed their initial clinical placement in the first year of their degree and were eligible for their second placement. One small regional campus out of the six campuses where the Bachelor of Nursing is offered was chosen because the principal researcher was located on this campus. All nursing students who were eligible for allocation to the clinical placement at the identified campus were sent an email by a research assistant and invited to participate. Six students out of a possible fifteen students responded and went on to participate in the study.

Methodology and Methods

The methodological principles in this research namely participation; is drawn from participatory action research (Kemmis et al., 2013); active learning as defined by Dewing

(2010) self-development and democratic processes as set out by Piper & Lazar (2018) and developing practical knowledge from the work of McNiff & Whitehead, (2011). Action research typically works through an action research cycle; similar to a plan, do, study, act and reflect (see Image 1 – action research cycle). The methods used in each part of the cycle can vary, however, they are all used in a way that enables the principles set out above to be realised as far as is possible for each participant. In this action cycle, planning consisted of co-constructing a learning resource with nursing students. In the doing phase of the action cycle (see Image 1), the resource was developed, with all participants reviewing and refining the resource prior to its implementation. During the study phase of the cycle (see Image 1), the participants were in practice and considered the impact of the resource on their ability to be proactive in their assessment and feedback. A participatory evaluation was undertaken with the participants to evaluate the effectiveness of the resource. In the final phase of the action research cycle, a reflective phase, researchers and student-participants pulled together reflections from during the other parts of the cycle and reflected on the 'bigger' process and outcomes and incorporated the findings into a learning resource for introduction and wide scale implementation into the following academic session.

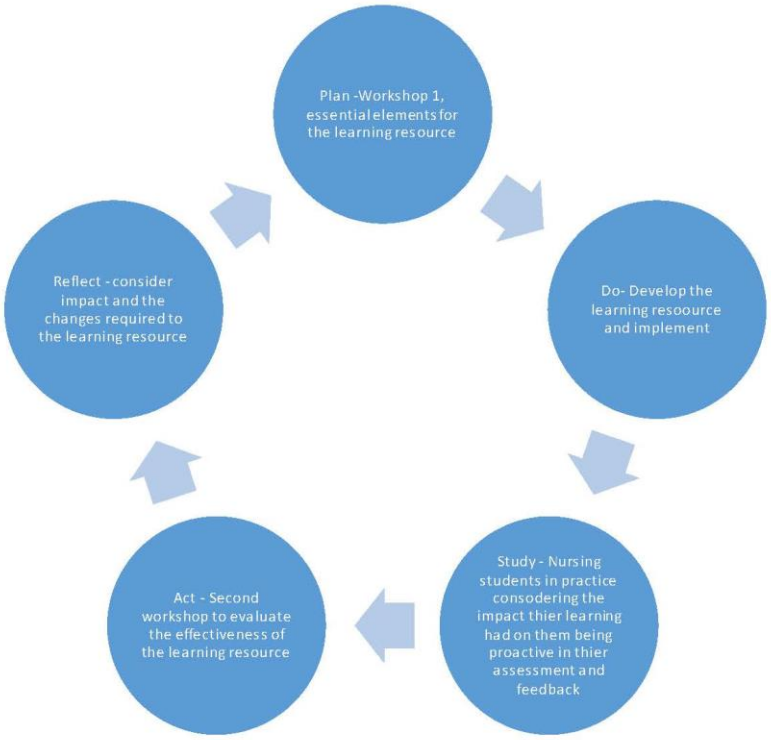

Image 1 – Action research process (Taylor et al., 2014)

In the workshops, we (the participants, principal researcher and co-researcher) made use of a variety of participatory learning oriented activities to maximise the group relationship and enable more open, wide ranging and authentic contributions. The group was facilitated by an academic staff member (who was also the PhD candidate) who has expertise in conducting active learning in groups and was not involved in the teaching or assessment of these nursing students in their subject related to their clinical placement. The group was also supported by one of the co-researchers. The facilitator invited the participants to describe and expand on what they found is required in preparing nursing students for clinical placement by undertaking a critical-creative reflection allowing each person to independently unlock their

understanding and learning. A group dialogue amongst the students as co-researcher then took place regarding the experiences and views raised, their meanings and implications for the style and content of the learning resource to unearth a deeper understanding and challenge participants to grow and develop as a part of the process (McCormack &Titchen, 2006). Both workshops were audio recorded and later transcribed. Handwritten notes were also taken by the second facilitator to capture any moments that might not stand out in audio recordings. The students as co-researchers then reviewed the transcripts and creatively represented their interpretation individually. Finally, we (students, second academic staff member and myself) came together as a group and created a shared story to answer the research question (McCormack & Titchen, 2006).

Ethics approval was granted via the University Human Research Ethics Committee (HREC) of the university. An ethical issue that was considered and explored within the ethics submission was perceptions of power. It is possible that participating nursing students would have some affiliation with at least one of the researchers, given two researchers' current work at the university this study was based in. The principal investigator in this research study holds a leadership position within the School of Nursing and provides governance for the clinical placement portfolio. To mitigate this, all correspondence in regards to participation information and consent was sent through a research assistant, so as to create a less powerful 'staff' space for the nursing student responses to the researchers and a second co-researcher was present for all meetings to ensure there were no issues of coercion or bias (Polit & Beck, 2017).

Findings

We will now present the three core findings; defining healthful relationships; emotional readiness and the participation of nursing students in the curriculum and what this might mean for person-centred learning and education in nursing.

The beginning of a definition of a healthful relationship between a nursing student and their clinical supervisor in clinical practice

This is the core finding from our research. Image 2 below is the student representation of a healthful relationship between the student and clinical supervisor. The participants initially considered what they thought a healthful relationship with the supervisor looked like and felt like for them. They drew a representation of this and used it to explain their perspective of an ideal relationship with the clinical supervisor. For this group of nursing students, a healthful relationship with their clinical supervisor included '*being able to have a voice even when you are shaky*" or having the courage and confidence to be heard [ie. to speak out loud] even when you are scared and anxious. It also includes an environment where it is *'ok knowing you are going to make mistakes'* and feeling comfortable and supported to learn through these. Feedback is an important part of the supervisory relationship and the participants agreed they need '*someone sincere with their feedback'*, rather than just saying what you want to hear. '*Ultimately, you need to have the courage to be true to your values and create a relationship that is authentic for both of you.'*

Image 2: nursing student's healthful relationship (image created by co-researchers)

Developing the learning resource – the student-led conversation

In the context of creating healthful supervisory relationships, we identified a gap in the processes by which the supervisory relationship was set up. After team dialogue we agreed to co-create a process that would enable the coming together and early connections within the supervisory relationship to be grounded in a co-owned values based discussion. This discussion, it was envisaged, would also include sharing and talking through hopes, fears and expectations about the placement. To ensure the process was easy to understand and could be up-scaled and replicated across all the campuses, a template was also designed to act as a guide for both students and supervisors. This template or guide has since become known as the *Student-Led Conversation Form*. The form is set out to incorporate particular topics that can be considered as part of the preparation for placement. These topics were organised into

the following sections: clarification of values, placement expectations and fears. The premise was for the student to start and lead the conversation and share their prepared thoughts and feelings with the clinical supervisor and then to have a conversation about the supervisor's expectations and come up with shared ways of working together. The student-led conversation form is now implemented into a larger clinical practice tool that students take into practice and is used with over 1500 students each academic session, (see Appendix A – Student led Conversation Form).

Prior to its introduction, students reported that they thought this process would open up communication and provide an opportunity to break the ice and ask questions of each other. While many references were made regarding the need to have a learning resource that enabled the nursing student to feel confident, the quotes that follow demonstrate how nursing students find there is a fine line between having the confidence to use your voice over being judged as overconfident by others including the supervisor:

> *'Not to be too confident but to have the courage to be confident... '*
>
> (Sallyanne)

> *'So basically having confidence in my abilities and it does say in here that we build self-confidence as we learn from our mistakes and improve for the better. Confidence brings strength to try new things and gain mastery through practice. So for us going out, or for myself going out, have that confidence in my skills and my abilities that I've learnt in my class and to put that into practice.'*
>
> (Tanya)

Finally, participants wanted to have clarity about expectations and who to go to if they needed assistance or support. The participant below explained she simply wanted clarity if she was having issues:

> *'If I'm having any issues, what do I do, who do I see'*
>
> (Ionna)

The process and form was developed and trialed with the six nursing students during their second clinical placement. Minor changes were then proposed and agreed based on the feedback received from workshop 2. There is a written introduction for nursing students to read out to the supervisor if they wish to, as starting the conversation was thought to be one of the most challenging aspects:

> *As part of the requirements for my placement, it would be really helpful to me for us to have a conversation about my values and how I am feeling about my placement.*
>
> *I would really appreciate it if we could spend a few minutes going over this form as it will guide us both through a process of sharing our thoughts about nursing and working with each other in clinical practice.*
>
> (Alicia)

The team then moved to consider the learning support that might be needed by students and supervisors to support wider implementation and sustainability of the process. Learning sessions and resources to further support the starting up of the student-supervisor conversation have been embedded within both nursing student and clinical supervisor pre-placement preparation. Learning from the experience of being in clinical placement and using the Student-Led Conversation Form were reported to generate a sense of confidence and courage within students by helping them to feel heard and validated.

Connection through vulnerability

Again, in the context of healthful relationships, students shared a sense that showing vulnerability helped in connecting on a more human(e) level with the clinical supervisor and contributed to being seen not 'just' as a nursing student, but rather a person that has their own uniqueness. It also helped the student nurse not to expect the clinical supervisor to be superhuman and understand they are doing the best they can to help everyone achieve the most from their placement. Further, the concept of belonging in the context of fitting in was explored with vulnerability. There was a reference to a ward or service being like a family

and that as a nursing student you are not familiar with the ways of being in that family and therefore do not belong:

> *'….hope that you'll be accepted into this family. It's quite a tricky situation, especially on the first day. You know, just even them looking at you and they know that you're a new face and you're in your student uniform, they've already got their family unit, and they've already got their conversations that they've had from the week before or asking each other about the weekend, and it's really hard to engage in those conversations as students because, obviously, we've never met them before.'*
>
> (Dan)

Vulnerability was considered in both workshops as being an aspect of connecting with your clinical supervisor on an authentic level. The discussion below demonstrates this:

': … we did talk about how even though we're, we're in a professional capacity we're still able to be vulnerable and 'cause we're all just, you know, still just people'

(Ionna)

> *'So we did talk about that. And everyone agreed, "Yeah, it's okay. It's okay. We can say we're scared or nervous or whatever.'*
>
> *(Louise)*
>
> *'I was the same 'cause on there you write how you're feeling and I had written that I was nervous about giving medications – and so I think it gives the clinical supervisor an area, okay, Sally-Anne's nervous about medication so maybe this is where we focus. …, I needed more support for that.'*
>
> *(Sally Anne)*
>
> *'I think it allowed the clinical supervisor an opportunity to come down to this, like, really, not come down, like to be in this real human moment. '*
>
> (Louise)

Emotional preparedness for clinical practice

Our second finding is about the degree to which students are emotionally 'ready' to connect within a healthful relationship. The participants spoke about how they were not prepared for creating a relationship with their clinical supervisors or the emotional challenge that clinical placement usually presented. The participants felt how they were prepared for the technical skills within their scope of practice, however, they were not prepared for engaging with their clinical supervisor:

> *'…. we spoke a lot about our scope of practice before we went on our first placement, that was really drummed into our heads but we weren't prepared with knowledge of what to expect when engaging with our clinical supervisor '*

(Tanya)

They also shared that they were not prepared for the emotional challenges that occur in the reality of clinical practice. The participants described this as:

> *'... being prepared to have bumps in the road'*

(Dan)

The participants felt that hearing from their peers who were in the second and third year of the degree program would help them to be more prepared for the reality of clinical practice

> *'I think that maybe some of the students from second or third year could maybe speak to the first years about their experience and how... We did speak to someone in their third year the week before we went, and I think that was helpful'*

(Ionna)

There are several questions to ask about how well nursing education is strategically designing for a workforce that is ready to respond to the needs of a healthcare system that is focusing more on the re-humanisation of healthcare (Broom, 2020) and on person-centredness in particular (Dickson et al., 2020). Core to this transformation is attending to the types of relationships between students and supervisors so that they move to being based on the principles of healthful relationships.

The participation of nursing students in the curriculum

The participants summarised their experience of participating in this research study with the following statement. It can be seen to demonstrate the learning about themselves and their ability to contribute and grow by having the courage to participate in a research study.
The participants shared that they gained insight into them having an active role in creating relationships and gained a level of confidence in themselves as they have contributed to the

development of a learning resource that will benefit not only themselves but many other nursing students. :

> *'Being a part of this Student-Led Conversation Project aimed at developing a new clinical placement assessment document has provided us with great insight not into our own fears about nursing placements, but has also enabled us to be involved in this project to assist the new first year nursing students in undertaking clinical placement. It is our belief that this tool will enable more open and empathetic communication between clinical supervisor/educators and nursing students, and in turn leading to a more harmonious and understanding working relationship, which we feel was broken or lacking originally.'*
>
> (Louise)

> *'We believe that this communication bridge can be achieved by understanding your own values and ethics, as well as openly communicating your goals and what you hope to learn from your time within the facility. We believe that by implementing these small communication changes, it will lead to a drastic but positive impact upon the way first year students view their clinical placements. It is our hope that by implementing these small changes with the new approach to clinical placement that we can enable open communication and shine a light on the stresses and fears of those initial placements.'*
>
> *(Alicia)*

Discussion

This research aimed to explore the experience of nursing students who were enabled to be active participants in the development of learning and teaching resources for their preparation for clinical placement. The findings have demonstrated that nursing students can be actively involved in preparing for their clinical placements and thus make active contributions to developing the curriculum as participants and co-researchers. Second, students can be active partners in initiating and shaping relationships with clinical supervisors, even in their first year. These findings have challenged those of Bradshaw et al. (2012) who propose preparation for clinical placement should occur in later years within a pre-registration nursing degree; as here we demonstrate that for this group of first year nursing students their understanding of the expectations and confidence to be in clinical placement was enhanced.

The findings in this research have highlighted how nursing students felt that being involved in this research enabled them to feel valued as a person and more confident in their interactions with clinical supervisors. This finding is similar to that by Levett-Jones et al., (2015) who advocate a shift to a more person (or student)-centred approach to learning and advocate that creative approaches to learning are required for appropriate preparation of nursing students for clinical placement and the work of the Person-centred International Community of Practice (Dickson et al., 2020; McCormack & Dewing, 2019). Nursing students feeling valued and heard promotes both confidence in their ability and a sense of belonging during their clinical placement (Levett-Jones et al., 2015; Eick et al., 2012), notwithstanding the many fears that nursing students have when entering clinical practice settings (Levett-Jones et al., 2015). Significantly, for the nursing profession, is that increasing a sense of confidence and of being valued within clinical placement is closely associated with satisfaction and willingness to complete pre-registration programs and continue in nursing (Eick et al., 2012).

The development of the Student-Led Conversation study and the courage that nursing students have in starting the conversation with vulnerability was reported to be instrumental in them creating person-person connections. The form is shared only between the nursing student and the direct clinical supervisor, and not any other registered nurses, as it is important that the student's vulnerability is protected. Students reported that the registered nurses on the ward that they work with at the bedside are unlikely to appreciate them sharing their values, fears and expectations of their placement. The technical busyness of the clinical environment feeds the general development of a 'doing' and busyness culture and one where being and taking time to be with others, consider values and to more deeply reflect on and understand how practice aligns to nursing theory and nursing paradigms is easily avoided.

Having a process and form as a tool to be used as part of a clinical placement helps to emphasise the importance of the 'being' or caring aspect of nursing and is considered an essential component of person-centred learning (O'Donnell et al., 2017). Further, the creation of personalised student learning experiences is argued to increase their motivation, trust and mutual respect (Knowles, 1986; Soloman, 1992; Wiseman, 2004).

The need for education and support for nursing students in their emotional preparedness for the reality of practice arose from the findings of this research study. Baron (2017) claims pre-registration curricula is currently teacher led and focused on the technical preparation for acute care practice. A key realisation for academic staff was that, within the School of Nursing, there was already in place learning and teaching strategies that included emotional preparedness for the clinical supervisors, however, not for the nursing students. Preparing nursing students for clinical practice is supported by Tuenissen and Westerman (2001, p. 291) who assert that preparing students for placement enables them to consider potential challenges and develop coping skills. Ross et al. (2017, p.593) supports the preparation for nursing students prior to a clinical placement in the context of final year students and found this can reduce stress and anxiety. On reflection, the oversight inadvertently contributed to increasing power imbalances and affected the ability of nursing students to prepare and understand their requirements in creating healthful relationships with their clinical supervisors. The nursing students' request to equalise this education is now in the process of being developed as part of a revised curriculum implementation.

In summary, there is little known in the literature about the impact the development of healthful relationships has on nursing students' ability to gain the maximum benefit from their clinical placement. The concepts of creating healthful relationships are embedded in the

theory of person-centredness and the creation of healthful cultures (McCormack & McCance, 2017). This research study created the foundation for further research within a PhD, to explore further, healthful relationships in the context of supervisory relationships in clinical practice. The participants advocated having their voice respected in this relationship enables them to have the courage to share their concerns in a situation where they feel stressed or anxious and enables them to be authentic to their values and beliefs. It is hoped that healthful (supervisory) relationships that enable nursing students to feel empowered will in part assist in creating a caring environment for them and their clinical supervisors to flourish to their full potential (McCormack & McCance, 2017; Bradbury et al., 2007).

Limitations

The limitation of this research study is that it was undertaken at a single site with limited participants which means the findings are relevant to the context the research was conducted within. This limitation is viewed as expected within an action research methodology where research in this paradigm is concerned with shared exploration of what people know, and how they learn to transform their social conditions. Person-centred research embedded in the critical paradigm accepts there are many realities and that the learning from this research study may have lessons for other contexts, (McCormack et al., 2017, p.44). However, this was not the paramount concern when undertaking this research.

Conclusion

In conclusion, this research study informed a larger PhD study and highlights the need for the students to be more active participants in the development of learning and teaching resources for their preparation for clinical practice. The Student Led Conversation Form has been now been implemented into all three years of the Bachelor of Nursing with over 1500 nursing

students now having 'start-up' conversations with clinical supervisors. This research study challenges the assumptions that are made about first year nursing students not being ready to prepare for clinical placement. There is a need for further research to be undertaken in regard to the impact nursing students can have as participants in developing learning resources to meet their learning needs in non-classroom settings. Specifically, further research is required into what constitutes s healthful (supervisory) relationship between nursing students and clinical supervisors in the context of clinical practice in order to further develop person-centred curricula.

References

Australian Nursing and Midwifery Accreditation Council (ANMAC). (2012). *Registered nurse accreditation standards.* https://www.anmac.org.au/sites/default/files/documents/ANMAC_RN_Accreditation_Standards_2012.pdf

Bailey, M. E., & Tuohy, D. (2009). Student nurses' experiences of using a learning contract as a method of assessment. *Nurse Education Today*, 29(7), 758-762. https://doi.org/10.1016/j.nedt.2009.03.012

Baron, K. A. (2017). Changing to concept-based curricula: The process for nurse educators. *The Open Nursing Journal*, 11, 277. doi: 10.2174/1874434601711010277

Barrington, K., & Street, K. (2009). Learner contracts in nurse education: Interaction within the practice context. *Nurse Education in Practice*, 9(2), 109-118. https://doi.org/10.1016/j.nepr.2008.10.004

Bradbury-Jones, C., Sambrook, S., & Irvine, F. (2007). The meaning of empowerment for nursing students: A critical incident study. *Journal of Advanced Nursing*, *59*(4), 342-351. doi: 10.1111/j.1365-2648.2007.04331.x

Bradshaw, C., O'Connor, M., Butler, M. P., Fahy, A., Tuohy, D., Cassidy, I., Quillinan, B., Egan, G., McNamara, M.C., & Tierney, K. (2012). Nursing students' views of clinical competence assessment. *British Journal of Nursing*, 21(15), 923-927. http://dx.doi.org.ezproxy.uow.edu.au/10.12968/bjon.2012.21.15.923

Broom, B. (2020). The practice of whole person-centred healthcare. In R. Anjum, S. Copeland, & E. Rocca. (Eds.) *Rethinking causality, complexity and evidence for the unique patient* (pp 215-226). Springer. https://doi.org/10.1007/978-3-030-41239-5_14

Dewing, J. (2010). Moments of movement: Active learning and practice development. *Nurse Education in Practice*. 10(1), 22-26. https://doi.org/10.1016/j.nepr.2009.02.010

Dewing, J. (2020).

Dickson C.A.W., van Lieshout, F., Kmetec, S., McCormack, B., Skovdahl, K., Phelan, A., Cook, N.F., Cardiff, S., Brown, D., Lorber, M., Magowan, R., McCance, T., Dewing J. & Štiglic, G. (2020). Developing philosophical and pedagogical principles for a pan-European person-centred curriculum framework. *International Practice Development Journal* 10(4). https://www.fons.org/library/journal/volume10-suppl2/article4_doi.org/10.19043/ipdj.10Suppl2.004

Eick, S. A., Williamson, G. R., & Heath, V. (2012). A systematic review of placement related attrition in nurse education. *International Journal of Nursing Studies*, 49(10), 1299-1309. https://doi.org/10.1016/j.ijnurstu.2011.12.004

Grace, S., & O'Neil, R. (2014). Better prepared, better placement: An online resource for health students. *Asia-Pacific Journal of Cooperative Education*, 15(4), 291-304.

Grace, S., McLeod, G., Streckfuss, J., Ingram, L., & Morgan, A. (2016). Preparing health students for interprofessional placements. *Nurse Education in Practice*, 17, 15-21. https://doi.org/10.1016/j.nepr.2016.02.001

Habermas, J. (1987). *Theory of communicative action*. Boston: Beacon Press.

Helminen, K., Tossavainen, K., & Turunen, H. (2014). Assessing clinical practice of student nurses: Views of teachers, mentors and students. *Nurse Education Today*, 34(8), 1161-1166. https://doi.org/10.1016/j.nedt.2014.04.007

Kemmis, S., McTaggart, R. &Nixon, R. (2013). *The action research planner: Doing critical participatory action research*. Springer Verlag.

Knowles, M. S. (1986). *Using learning contracts: Practical approaches to individualizing and structuring learning*. Jossey-Bass.

Levett-Jones, T., Pitt, V., Courtney-Pratt, H., Harbrow, G., & Rossiter, R. (2015). What are the primary concerns of nursing students as they prepare for and contemplate their first clinical placement experience?. *Nurse Education in Practice*, 15(4), 304-309. https://doi.org/10.1016/j.nepr.2015.03.012

McCormack, B., & Dewing, J. (2019). An exploration of how healthful relationships between student and clinical supervisor influence transformational learning: A person-centred inquiry. *International Practice Development Journal*, 9(1), 9. https://doi.org/10.19043/ipdj.91.003

McCormack, B., &. McCance, T. (2017). *The person-centred practice framework. Person-centred practice in nursing and health care: theory and practice* (Eds.). John Wiley & Sons.

McCormack, B., van Dulman, S., Eide, H., Skovdahl, K., & Eide, T. (2017). *Person-centred healthcare research* (Eds.). Wiley-Blackwell

McCormack, B., & Titchen, A. (2006). Critical creativity: Melding, exploding, blending. *Educational Action Research*, 14(2), 239-266. https://doi.org/10.1080/09650790600718118

McNiff, J., & Whitehead, J. (2011). *All you need to know about action research*. Sage Publications.

O'Donell, D., Cook, N.F., & Black, P. (2017). Person-centredness in nursing education. In B. McCormack & T. McCance (Eds.), *Person-centred practice in nursing and health care: Theory and practice* (pp. 99-117). Wiley-Blackwell.

O'Mara, L., McDonald, J., Gillespie, M., Brown, H., & Miles, L. (2014). Challenging clinical learning environments: Experiences of undergraduate nursing students. *Nurse Education in Practice*, *14*(2), 208-213.https://doi.org/10.1016/j.nepr.2013.08.012

Piper, A. M., & Lazar, A .(2018). Co-design in health: What can we learn from art therapy? *Interactions*. 25(3), 70-73 https://doi.org/10.1145/3194353

Polit, D. F., & Beck, C. T. (2017). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). Lippincott Williams & Wilkins.

Ross, L. J., Mitchell, L. J., & Williams, L. T. (2017). Is it possible to enhance the confidence of student dietitians prior to professional placements? A design-based research model. *Journal of Human Nutrition and Dietetics*, 30(5), 588-595. https://doi.org/10.1111/jhn.12479

Solomon, P. (1992). Learning contracts in clinical education: Evaluation by clinical supervisors. *Medical Teacher*, *14*(2-3), 205-210. https://doi.org/10.3109/01421599209079489

Spiliotopoulou, G. (2007). Preparing occupational therapy students for practice placements: Initial evidence. *British Journal of Occupational Therapy*, 70(9), 384-388. https://doi-org.ezproxy.uow.edu.au/10.1177/030802260707000903

Stunden, A., Halcomb, E., & Jefferies, D. (2015). Tools to reduce first year nursing students' anxiety levels prior to undergoing objective structured clinical assessment (OSCA) and how this impacts on the student's experience of their first clinical placement. *Nurse Education Today*, 35(9), 987- 991. https://doi.org/10.1016/j.nedt.2015.04.014

Taylor M J., McNicholas C., Nicolay C, Darzi, A., Bell, D., & Reed, J. (2014). Systematic review of the application of the plan–do–study–act method to improve quality in

healthcare. *BMJ Quality & Safety*, 23, 290-298. https://qualitysafety.bmj.com/content/23/4/290

Teunissen, P. W., & Westerman, M. (2011). Opportunity or threat: The ambiguity of the consequences of transitions in medical education. *Medical Education*, *45*(1), 51-59. doi:10.1111/j.1365-2923.2010.03755.x

Wieseman, K. (2004). Use of learning agreements in preservice secondary science teacher preparation: joys, struggles, tensions, empowerment issues. In *Annual Meeting of the National Association for Research in Science Teaching. Retrieved June* (Vol. 19, p. 2007).

Appendix A – STUDENT LED CONVERSATION: Establishing ways of working between nursing students and clinical supervisors

This page has intentionally been placed at the beginning of the assessment in practice document to provide you the nursing student, with an outline to introduce yourself to your clinical supervisors. Most important, is that you have the opportunity to share your values, how you are feeling about this placement and establish ways of working with your clinical supervisor. Clinical supervisors can reciprocate and introduce themselves to you too. This is intended to be part of a conversation led by you, the nursing student.

In starting the conversation it is expected that the clinical supervisor provides time to sit quietly with the nursing students either individually or as a group and allows the nursing student to start the conversation and share with you their values, feeling and expectations. This conversation should occur on Day 1 of the placement.

Suggested way to start the conversation

> *As part of the requirements for my placement it would be really helpful to me for us to have a conversation about my values and how I am feeling about my placement.*
>
> *I would really appreciate if we could spend a few minutes going over this form as it will guide us both through a process of sharing our thoughts about nursing and working with people in clinical practice.*

Hello, My Name is _____

I value the following when I am in the role of a nurse caring for people in practice

- _____
- _____
- _____
- _____

I have the following feelings about this workplace experience placement

- _____
- _____
- _____
- _____

I have the following expectations of my experience of clinical supervision during this workplace experience placement

- _____
- _____
- _____
- _____

Could you please share with me your expectations of me as a nursing student during this workplace experience placement?

- _____
- _____
- _____
- _____

The following are our agreed ways of working together

- _____
- _____

Appendix E

Student Led Conversation Form

Appendices

Appendix A – STUDENT LED CONVERSATION: Establishing ways of working between nursing students and clinical supervisors

This page has intentionally been placed at the beginning of the assessment in practice document to provide you the nursing student, with an outline to introduce yourself to your clinical supervisors. Most important, is that you have the opportunity to share your values, how you are feeling about this placement and establish ways of working with your clinical supervisor. Clinical supervisors can reciprocate and introduce themselves to you too. This is intended to be part of a conversation led by you, the nursing student.

In starting the conversation it is expected that the clinical supervisor provides time to sit quietly with the nursing students either individually or as a group and allows the nursing student to start the conversation and share with you their values, feeling and expectations. This conversation should occur on Day 1 of the placement.

Suggested way to start the conversation

> *As part of the requirements for my placement it would be really helpful to me for us to have a conversation about my values and how I am feeling about my placement.*
>
> *I would really appreciate if we could spend a few minutes going over this form as it will guide us both through a process of sharing our thoughts about nursing and working with people in clinical practice.*

Hello, My Name is _____

I value the following when I am in the role of a nurse caring for people in practice

- _____
- _____
- _____
- _____

I have the following feelings about this workplace experience placement

- _____
- _____
- _____
- _____

I have the following expectations of my experience of clinical supervision during this workplace experience placement

- _____
- _____
- _____
- _____

Could you please share with me your expectations of me as a nursing student during this workplace experience placement?

- _____
- _____
- _____
- _____

The following are our agreed ways of working together

- _____
- _____

Appendix F

Publication - Making sense of critical participatory action research. Reflections on The Action Research Planner: Doing Critical Participatory Action Research

International Practice Development Journal

Online journal of FoNS in association with the IPDC (ISSN 2046-9292)

IDEAS AND INFLUENCES

Making sense of critical participatory action research. Reflections on *The Action Research Planner: Doing Critical Participatory Action Research*

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Introduction

After immersing myself in *The Research Planner: Doing Critical Participatory Action Research*, I believe I have a better understanding of participatory action research and its relationship to the work of Habermas. I feel it has enabled me to align my values and beliefs with Habermas and action research's philosophical underpinnings within the critical theory paradigm. For me this book has clarified how communicative spaces, the theory of communicative action and public spheres are related to participatory methodologies.

At the start of the book, Kemmis and co-authors (2013, pp 2-3) define the purpose of critical participatory action research as 'to change social practices, including research itself, to make them more rational and reasonable, more productive and sustainable and more just and inclusive'. 'Rational' in this context conveys a sense of being more reasonable, comprehensible, coherent and sensible. Carr and Kemmis (1986) critique the positivist and interpretivist paradigms and argue that for critical participatory action research to bring about social change, it needs to reject the premise of objectivity whereby the researcher is viewed as a 'distant observer'. They further advocate that self-reflection is essential, for the individual and the collective, to ensure the critical aspect and validity of the research. Overall, they say participatory forms of research methodology create the conditions for practitioners to be activity involved and have a voice in all aspects of the research process (Kemmis et al., 2013).

A meaningful learning for me has been the realisation that critical participatory action research is not a series of iterative cycles that lead on from each other but rather a self-reflecting spiral that is continuous. This realisation may, on the surface, seem obvious. However, it is a longstanding assumption for me that has now been unpacked and I have gained a new perspective on how to participate in this form of research. The significance of this is that within my values and beliefs, I feel registered nurses should be active in decision making and able to influence their environment. Having a spiral that is ongoing – which includes the process of planning a change, acting and observing the process and consequences of the change, reflecting on the process, and then replanning and so on – allows for overlapping and a more fluid movement of participants in and out of the process. Having an ongoing spiral enables the process of critical participatory action research to be determined by the participants, rather than the research process (Kemmis et al., 2013).

Figure 1: Creative representation of self-reflective spiral

I have been able to make sense of the relationship between Habermas' (1987) *Theory of Communicative Action*, the role of participation in the public sphere in how this relates to communicative action and communicative spaces. A public sphere is created when a group of people with a common interest come together to explore a problem or an issue. I value that in our interactions with others; as researchers we need to respect others' expertise and value the contribution they make. Within critical participatory action research, participants or co-researchers come together and talk about their workplace and their values, and come to a mutual consensus or shared understanding. Therefore they are active in the process and their expertise is both recognised and valued. Most importantly the issue of power is explored and recognition is given that we are not all equal. Research groups need to value and explore difference in open and honest ways, and agree on ways of working that mitigate or minimise the power distribution to create a safe communicative space. Such a space allows them to remove themselves from organisational constraints and dare to dream (Kemmis et al., 2013).

The process of participating in communicative action occurs with a communicative space. This is a place where participants are free to be open and honest, and respect each other's ideas and perspectives. From a critical participatory action research perspective, this requires a space where conversations are conducted respectfully, there is a sincere attempt among participants to reach unforced consensus and difference is appreciated. Safety is created within communicative spaces where participants engender a sense of cohesion with shared decision making. This cohesion itself ensures there is validity and legitimacy in the attainment of unforced consensus. Validity and legitimacy are essential in critical participatory action research and can only be achieved through communicative action where participants are free to decide what is comprehensible to them, what they believe is the truth, what they believe to be sincerely stated and what seems to be morally right and appropriate at a given point in time (Kemmis et al., 2013, p 36).

In conclusion, critical participatory action research involves the research team and the participants being committed to an ongoing discourse that aims to consider practice differently in an open and

honest way, enabling the rethinking of clinical practice. Communicative action aims for change in practice that is more rational and reasonable, more productive and sustainable, and more just and inclusive.

References

Carr, W. and Kemmis, W. (1986) *Becoming Critical: Education, Knowledge and Action Research.* London: Falmer Press.

Habermas, J. (1987) *Theory of Communicative Action.* Boston: Beacon Press.

Kemmis, S., McTaggart, R. and Nixon, R. (2013) *The Action Research Planner: Doing Critical Participatory Action Research.* Singapore: Springer Verlag.

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Appendix G

Publication - How do emoji facilitate learners within the context of healthcare education research? A scoping review.

INTRODUCTION

A recent and increasingly popular form of communication around the globe, originating in Japan in 1997, is the emoji, derived from two Japanese words for the meaning of picture and character, characterising emotions and feelings (Gilles Doiron 2018). This technologically based pictorial method has overtaken emoticons as a preferred creative form of communication (Lotfinejad et al., 2020; Troiano and Nante 2018). Pictorial communication is, however, not a new phenomenon, with language considered to have begun in a pictorial format in the form of cave paintings, morphing over time into the written word (Seargeant 2019). The recent technological uptake of emoticons and emoji provide a connection of pictorial communication from the historic symbolic language to the present pictorial forms of communication (Bhattacharya 2019).

Emoji are becoming more sophisticated with pictorial representation that began as facial expressions now expanded to include other representations such as food, animals, and a huge range of other symbols (Willoughby and Lui 2018; Fane 2017). Emoji are defined as a graphical symbol that 'express concepts and ideas used in mobile communication and social media' (Fane 2017, p. 98). Their emergence in Western culture technological communication has been more evident since 2011 following the launch of Apple IOS5 (Troiano and Nante, 2018). The number of emoji is dynamically increasing and diversifying as they gain popularity. There are currently over two thousand emoji in use (Lotfinejad et al., 2020; Troiano and Nante 2018).

Although the use of emoji is increasing in popularity, some fields of research have been slow to adopt the emoji. Although emoji have been used as a research information collection in other contexts, their use in health education research seems limited (Bai et al, 2019). Several authors argue that the use of emoji in research is limited and requires

further exploration (Donovan 2016; Gilles Doiron 2018; Lotnejad et al., 2018; Bai et al 2019). We agree that this is the case in healthcare education, including in nursing education. Bai et al (2019) specifically identified a need for further research that explores how emoji are used in research to connect with emotion and from an inter-personal perspective.

There are of course limitations to the use of emoji as a system of communication. More broadly, there are also cultural differences as to what emoji are preferred and how they are interpreted. From an educational perspective, future qualitative research needs to acquire a better understanding of this real world communication to make the best use of it. To address our current gap of knowledge in the use of emoji as a research information collection tool in the context of healthcare higher education, a scoping review was conducted to explore the current knowledge base.

This scoping review is embedded within a larger person-centred (and therefore participatory) PhD research study where emoji have been utilised as an information collection tool for exploring the supervisory relationship between nursing students and their clinical supervisors in the reality of clinical practice. A person-centred perspective as defined by McCormack and McCance (2017) was therefore adopted as the theoretical lens within the review of the literature. Person-centredness is defined as

> "---an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual rights to self-determination, mutual respect and understanding, It is enabled by cultures of empowerment that foster continuous approaches to practice development" (McCormack and McCance 2017, p.3).

The ultimate outcome for person-centred practice is taken from a salutogenic

perspective to encompass the creation of healthful cultures that have at their core healthful relationships.

AIM

This scoping review aims to identify all relevant literature that explores the influence of emoji in healthcare educational research in a tertiary education setting to understand the use of emoji as an information collection method.

METHOD

A scoping review in line with the sentinel work outlined by Arksey and O'Malley (2005) and enhanced by Levac et al. (2010) was chosen to conduct the review of literature on the use of emoji in healthcare education research. The term scoping review was chosen as opposed to scoping study as a review is best situated with the concept of a literature review. Arksey and O'Malley (2005) advocate for the term study whereas others more recently have preferred the term scoping review (Levac et al. 2010; Pham et al. 2014; Peterson et al. 2017). Pham et al (2014) further argue that using the term review rather than study takes the focus of the review from a rapid approach to a literature review.

Arksey and O'Malley (2005, pp. 22-25) identify a six-stage iterative process to conduct a scoping review. These six stages are identifying the research questions, identifying relevant literature, study selection, charting the information, collating, summarizing, and reporting the findings and consultation. In this scoping review, five of these stages were adopted with the optional sixth stage of consultation not being undertaken as this review was considering the current knowledge base within the literature.

Identifying the research question

A clear research question is imperative and features in the first stage of the Arksey and O'Malley (2005) scoping review model. Two of the authors explored the use of emoji and considered the most relevant question about the use of emoji in the context of the research to be: How do emoji facilitate learners within the context of healthcare education research? The review question was derived following critical dialogue between the two authors undertaking the review; which we argue enhanced criticality in the research.

Identifying relevant literature

The second stage is to identify relevant literature (Arksey and O'Malley 2005). We followed the PRISMA statement (Moher et al., 2009) as this allowed our method to adopt an evidence-based approach to identifying and collating relevant literature.

Search Strategy

A search strategy was completed to determine the current body of knowledge related to the use of emoji with learners in healthcare education at a tertiary education level. The search was broad with the intention to start wide and narrow the search further if required. Literature searches were completed using three relevant databases (Scopus, Web of Science (including ERIC ProQuest) and a Google Scholar search). The databases were selected because Scopus has a focus on multidisciplinary health related journals, Web of Science has a social science focus and ERIC houses education resources. A Google Scholar search was also included as the topic of emoji is dynamic and contemporary and captures online journal publications that may not be identified within a traditional database search.

Searches were undertaken using a variety of search titles according to the sections within the databases. The search terms of *emoji* and *education* and *health* were used consistently in each of the searches to capture similarities across the searches and then were modified once the initial search was completed. The search strategy for each search are detailed below:

Table 1 – Search strategy

The search in Table 1 above revealed a small amount of literature in the broad sweep related to the research question. Although a large number of articles were initially revealed in the ERIC search, none of these articles were related to health, therefore affirming our assertion that there is a gap in both the current literature and evidence for the use of emoji.

Study Selection

The third stage of Arksey and O'Malley's scoping review model is study selection; and this was guided by using the PRISMA flow chart (Moher et al., 2009). The initial search generated thirty-six publications for review, duplicates were removed leaving thirty-three publications identified for abstract review. The first step of the study selection process was an abstract review completed by two of the authors using agreed inclusion and exclusion criteria, this identified seven articles for inclusion. Reference lists from the included publications were reviewed for relevant literature as determined by the research question. This process resulted in a further eighteen publications included in the abstract review and two further publications being included in the review. The following PRISMA diagram (Figure 1) demonstrates the process followed.

Figure 1 – PRISMA Flow diagram

Charting the Information

Arksey and O'Malley (2005) recommend charting retrieved information as the fourth stage of the scoping review. The seven identified articles that would contribute to the review were all reviewed in their full text published form. All seven articles were read by the two authors initially with each reviewer undertaking a narrative review. This approach meant that agreed information based on the research question was captured and recorded in a preformatted spreadsheet. Booth et al (2012) refer to this initial step as a naïve read of the literature. At this point, we adapted Arksey and O'Malley model by adopting the work of Booth et al (2012), while both authors conducted a more detailed and considered second read. This required both authors to re-read each article looking for greater depth and meaning and then to contemplate the key ideas relevant to the research question and through the person-centred theoretical lens.

FINDINGS

The final stage of the scoping review includes collating, summarizing, and reporting the findings (Arksey and O'Malley 2005). Seven full text publications were included within this scoping review, five discussion or expert option level papers were considered; one publication was qualitative research and the final one was a systematic literature review. The publications have an international perspective with one paper each from Australia, United Kingdom, United States of America, Italy, Qatar, Iran, and Switzerland. The settings are all health and primary healthcare education oriented. ERIC is an educational database and the search of this revealed no studies on emoji that had a healthcare relationship. The search strategy was not limited in SCOPUS or Web of Science, however by contrast Google Scholar was limited to 2010 to 2020 given the historical development of Emoji. Papers identified for inclusion were from 2016 to 2020

consistent also with the recency of the interest and use of emoji in healthcare education.

A summary of the information charted is included in Table 2 below.

Table 2- Summary of the scoping review included articles.

Themes

Three tentative themes were identified relevant to the research question from this scoping review. Although there were a small number of papers in the review, the themes that emerged were clear to both authors. The themes are discussed in order of their perceived significance within the literature review. They are the semiotics of emoji; cultural and contextual influences on the emergence of emoji in healthcare research and the emergence of emoji as a research method and tool for the facilitation of learning. Each of these themes will now be explored from the perspective of the emoji as a information collection tool in research.

1. The semiotics of emoji

Semiotics in the context of emoji is a prominent theme across all reviewed papers and as defined by Seargeant as "*the study of how we use signs to convey meaning.*" (2017, p.14). Meaning or the interpretation of emoji can be both individual or open-ended and if symbols are universally understood, some would advocate they have become more appealing as a technological form of communication (Bhattachary et al 2019; Gilles Doiron 2018). Willoughby and Lui (2018) contend that rather than a common agreement on meaning, it is open to individual interpretation that enables connection with emoji through personalisation of the meaning. Fane (2017, p.104) in their qualitative study put forward the idea that emoji use in research allows the participant to construct their own meaning and perspective. Overall, whilst there is agreement emoji

are useful to convey a message, there is mixed opinion about the usefulness of interpretation of the meaning of emoji.

Emoji face icons provide a connection with the message for people by personalising the message with facial expressions argued to be important in non-verbal communication (Troiano and Nante 2018; Willoughby and Lui 2018). Most significantly, this form of emoji use as a research information collection tool provides evidence that suggests emoji are useful for enabling people to connect with their emotions, feelings, and behaviours (Gilles Doiron 2018; Troiano and Nante 2018; Willoughby and Lui 2018). Troiano and Nante (2018) in their systematic review identified that the use of emoji enhanced the doctor-patient relationship. This perspective was found to be important by Willoughby and Lui (2018) who contend that emoji assisted people to express their feelings and emotions. Interestingly and relevant to the PhD study about healthful relationships, emoji were identified by participants as useful in enabling them to connect to their feelings and emotions regarding a supervisory relationship between students and clinical supervisors. Donovan (2016) reported that the use of emoji for responding to others freed the person from the pressure of answering the question, providing a medium for enabling communication. Additionally, the use of emoji for communicating health messages that were perceived to be less interesting resulted in higher levels of participant attention (Gilles Doiron 2018). Gilles Doiron (2018, p.3) asserts that messages using emoji are interpreted in the broader context of the relationship between the sender and the receiver.

2. *Cultural and contextual influences on the emergence of emoji in healthcare research*

Contexts evident in the literature had a focus on delivering health messages, primary

healthcare education and with younger people, as a tool for communication about pain and feelings. All seven papers spoke to this theme. The papers came from a range of countries and offer a limited international perspective (Donovan 2016; Fane 2017; Gilles Doiron 2018; Willoughby and Lui 2018; Troiano and Nante 2018; Bhattacharya et al 2019; Lotfinejad et al 2020). There have been calls for emoji to be seen as a universal mode of informal pictorial based communication (Willoughby and Lui 2018; Bhattacharya et al 2019; Gilles Doiron 2018). However, Gilles Doiron (2018), challenges this intention. Further, both Google and Apple have provided different interpretations of emoji across different countries. An attempt has been made to create a universal set of emoji by the World Health Organisation (WHO) for tuberculosis (Bhattachary et al 2019). Plus, the development of a common understanding of the FiveMoments of Hand Hygiene, emoji have helped to create messages that are universally understood. Lotfinejad et al (2020) advocate there is the need to develop common sets of emoji by WHO for healthcare professionals and people in their care.

We suggest that given interpretations of emoji are made by users within the context of relationships, there will be varying social and cultural factors influencing the process. Emoji could be useful from cultural and contextual perspectives to bridge communication gaps, however, this use would require the development of a common understanding in contexts where a shared understanding would be beneficial(Gilles Doiron 2018; Troiano and Nante 2018; Willoughby and Lui 2018; Bhattacharya et al 2019; Lotfinejad et al 2020).

3. *The emergence of emoji as a research method and tool for the facilitation of learning*

Six of the seven articles reviewed ideas relevant to advances in technology and

consequently led to the creation of this theme and the emergence of emoji as a research information collection tool. The popularity of emoji in this context began with the use of the facial expression emoji and this has enabled the progression and enhancement of emoji use and its applicability as a message, in a way that the written text alone is not able to achieve (Gilles Doiron 2018; 2018; Willoughby and Lui 2018). Fane (2017, p. 96-97) in a qualitative research paper argues that *"visual research has a strong link with technology"* and that the use of emoji as a research information collection tool has the *"potential to produce new, innovative, reflexive and theoretically informed research"* through its diversity in connection and purpose. This is at present an aspiration rather than a reality.

The commonality of technology uses and devices has contributed to the popularity of emoji in communication. This subsequently had led to them being a successful learning tool and creating interest for use in healthcare education research (Lotfinejad 2020; Willoughby and Lui 2018). Emoji have been shown in the identified papers to be a tool that enables engagement and learning as they are generally easy to connect with (Fane 2017; Gilles Doiron 2018; Troiano and Nante 2018; Bhattachary et al 2019). Further, we propose that they leave a more open space for the receiver to be actively involved in the creation of meaning. Furthermore, from a learning perspective, emoji have been utilised in online forums, focus groups, and the provision of peer feedback (Fane 2017; Gilles Doiron 2018). As a healthcare education collection tool, emoji have demonstrated applicability to learning and to sharing messages as with the WHO tool.

DISCUSSION

This scoping review explored the question, How do emoji facilitate learners within the context of healthcare education research? Overall, there is insufficient evidence to draw

any conclusions, there is however reason to be hopeful about the possibilities. The review included publications that considered how emoji enabled a connection to feelings and linked this to exploring responses and developing personal insights (Gilles Doiron 2018; Troiano and Nante 2018; Willoughby and Lui 2018). None of the scoping review publications considered the development of person-centred relationships or healthful relationships. There is evidence within this scoping review that emoji influences a connection to healthcare education and learning. This evidence comes mainly from primary healthcare settings and services provided to young people. More research is needed in other contexts and groups of users.

Gilles Doiron (2018) commented that the emoji in higher education is a useful tool for making connections, for communication, and to provide peer feedback. Emoji have the potential for inclusion in the creation of person-centred learning cultures. Within the PhD study that surrounds this scoping review, participants have reported that taking time to reflect on how their supervisory relationship has influenced them connected them to their learning and their awareness of transformative learning experiences. Emoji use promotes self-awareness (Bai et al., 2019) and from a person-centred practice perspective, influences the pre-requisite of knowing self (McCormack and McCance 2017), fundamental for person-centredness. Bai et al., (20019) propose there is a need for further research on the application of the use of emoji as a learning tool and they emphasise the applicability to online learning. The outcomes of this scoping review support this proposal and also suggests that the use of emoji in research could be further expanded to explore their use as a research method and in participants' ability to be self-reflective so they may connect to their values and beliefs across a variety of learning environments.

The scoping review aimed to consider the literature regarding the influence of emoji in

a higher education context including research to understand the use of emoji as a research tool. There was limited evidence of emoji as a research tool in practice and its application in a higher education setting. The evidence included within this scoping review is largely at the level of discussion or expert opinion demonstrating the need as identified by Bai et al (2019), for further research to be undertaken., The preliminary findings from the PhD suggest that emoji are a research method that enables reflection and connection to emotions and feelings and a stimulus for self-reflection. We argue that emoji also have a role to play in person-centred healthcare research building on the current descriptive nature of what is known about the use of emoji to a more robust evidenced based approach to the use of emoji in humanistic healthcare research.

More broadly within person-centred perspective, emoji offer a creative tool for communication, which some people will find a meaningful and helpful means of connecting and communicating. Jacobs et al (2017) drawing on Gergen (2009) suggest that connectivity is central to persons. This connectivity is necessary to construct knowledge and for learning. Learning from connecting to self and emotions has been demonstrated within this literature review (Gilles Doiron 2018; Troiano and Nante 2018; Willoughby and Lui 2018). In essence, person-centred researchers do research *with* other persons. Emoji offer some people a way of participation and perhaps a sense of empowerment that they may otherwise not achieve.

The limitations to this review include the broad approach a scoping review takes and the small number of publications available at present. Whilst Booth et al., (2012) argue that a scoping review provides the basis to assess the ongoing need for research, this review has made an early assessment of the state of the published evidence on this topic.

CONCLUSION

The diversity and applicability of emoji as a research tool that enables participants to connect to their ways of being, emotions and feelings are evident in the literature albeit largely at an expert opinion level. This scoping review found little empirical research evidence on the use of emoji in healthcare education researchand concludes that emoji has the potential to contribute positively within contemporary research approaches. The publications found were largely at the level of discussion and therefore, further research is required to expand the empirical research evidence base.

Impact Statement

The understanding of the use of emoji as a research information tool is limited and this paper contributes to what is known about their applicability to health education research. This scoping review demonstrated the use of emoji as an information collection tool enables persons to connect with their emotions when considering their contributions to the research topic. The use of emoji in health education research has demonstrated the applicability of emoji in enabling connection, communication and feedback. Connectivity is a principle within person-centred research and therefore the creative use of emoji provides connection to self awareness and embodied knowing.

Conflict of Interest

There were no potential competing interests reported by the authors.

REFERENCES

Arksey, H., & O'Malley, L. (2005). Scoping Studies: Towards a Methodological Framework.*International Journal of Social Research Methodology: Theory & Practice, 8*(1), 19–32.https://doi.org/10.1080/1364557032000119616

Bai, Q., Dan, Q., Mu, Z., & Yang, M. (2019). A systematic review of emoji: Current research and future perspectives. *Frontiers in Psychology*,*10*, 2221. https://doi.org/10.3389/fpsyg.2019.02221

Bhattacharya, S., Singh, A., &Marzo, R. R. (2019). Delivering emoji/icon-based universal healthcare education messages through smartphones.*AIMSPublic Health*,*6*(3), 242–247. https://doi.org/10.3934/publichealth.2019.3.242

Booth, A., Papaioannou, D., & Sutton, A. (2012).*SystematicApproaches to a Successful Literature Review* London: Sage.

Donovan, D.P. (2016). Mood, emotions and emojis: conversations about health with young people.*Mental Health Practice, 20*, 23-26. https://doi.org/10.7748/mhp.2016.e1143

Fane, J. (2017). Using emoji as a tool to support children's wellbeing from a strength-based approach.*Learning Communities Journal*, *21*(Special Issue November 2017), 96-107.

Gilles Doiron, J. A. (2018). Emojis: Visual communication in higher education. *PUPIL: International Journal of Teaching, Education and Learning*, 2(2) 01-11.DOI-https://dx.doi.org/10.20319/pijtel.2018.22.0111.

Gergen, K. J. (2009). *Relational being: Beyond self and community.* Oxford University Pres.

Jacobs, G., van Lieshout, F & Borg, M. (2017) Being a person-centred researcher: principles and methods for doing research in a person-centred way. In McCormack, B., van Dulmen, S., Eide, H., Skovdahl, K. and Eide, T. (eds) *Person-centred Healthcare Research* (PP. 51-60). Oxford, Wiley-Blackwell. https// doi:10.1002/9781119099635.ch4

Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: advancing the methodology.*Implementation ScienceIS,* 5, 69. https://doi.org/10.1186/1748-5908-5-69

Lotfinejad, N., Assadi, R., Aelami, M. H., &Pittet, D. (2020). Emojis in public health and how they might be used for hand hygiene and infection prevention and control.*Antimicrobial Resistance and Infection Control*,9(1).https://doi.org/10.1186/s13756-020-0692-2

McCormack, B. and McCance, T. (2017).*Person-centred Practice in Nursing and Health care: Theory and Practice.* (2nd ed.). United States: John Wiley & Sons.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & PRISMA Group (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement.*PLoSMedicine*,6(7), e1000097. https://doi.org/10.1371/journal.pmed.1000097

Munn, Z., Stern, C., Aromataris, E., Lockwood, C., & Jordan, Z. (2018). What kind of systematic review should I conduct? A proposed typology and guidance for systematic reviewers in the medical and health sciences.*BMC medical research*

methodology,18(1), 5. https://doi.org/10.1186/s12874-017-0468-4

Peterson, J., Pearce, P. F., Ferguson, L. A., & Langford, C. A. (2017). Understanding scoping reviews: Definition, purpose, and process.*Journal of the American Association of Nurse Practitioners,* 29(1), 12–16. https://doi.org/10.1002/2327-6924.1238

Pham, M. T., Rajić, A., Greig, J. D., Sargeant, J. M., Papadopoulos, A., & McEwen, S. A. (2014). A scoping review of scoping reviews: advancing the approach and enhancing the consistency.*Research synthesis methods,* 5(4), 371–385. https://doi.org/10.1002/jrsm.1123

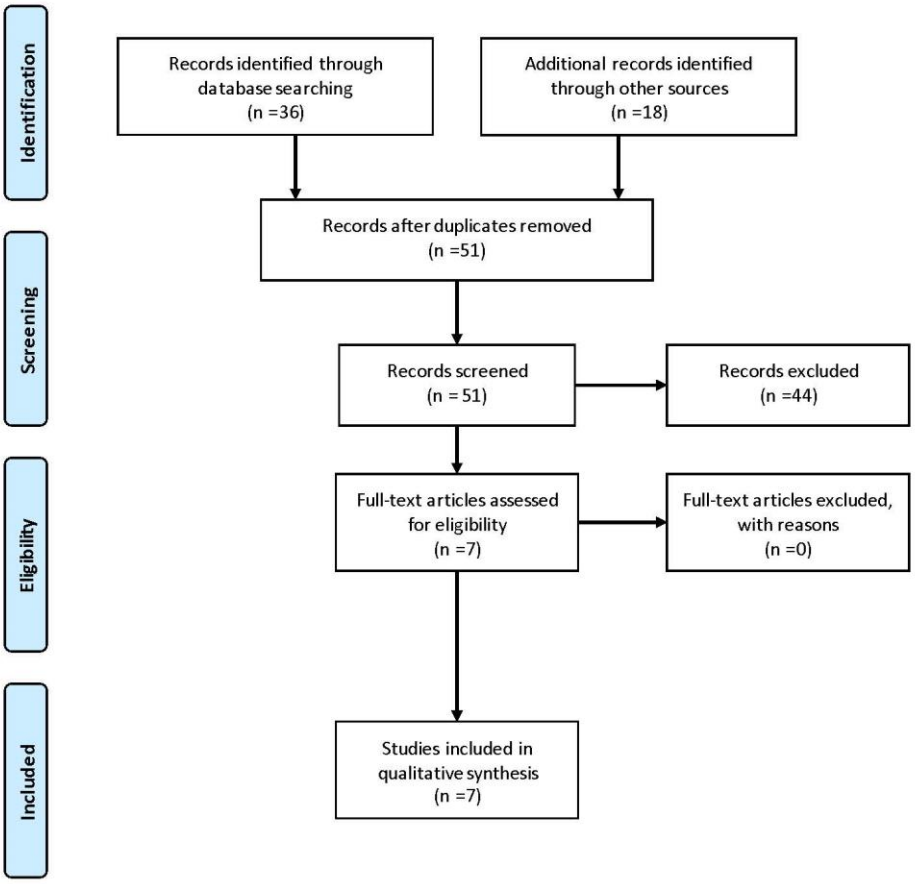
Seargeant, P. (2019). *The emoji revolution: how technology is shaping the future of communication.*University Press.https://doi.org/10.1017/9781108677387

Troiano, G., &Nante, N. (2018). Emoji: What does the scientific literature say about them?-A new way to communicate in the 21th century.*Journal of Human Behavior in the Social Environment,* 28, 528 - 533.https://doi.org/10.1080/10911359.2018.1437103

Whittemore, R.,Chao, A.,Jang, M.,Minges, K. E., &Park, C.(2014).Methods for knowledge synthesis: An overview.*Heart and Lung*,43(5),453–461. https://doi.org/10.1016/j.hrtlng.2014.05.014

Willoughby, J.F., & Liu, S. (2018). Do pictures help tell the story? An experimental test of narrative and emojis in a health text message intervention.*Computers in Human Behaviour, 79*, 75-82. https://doi.org/10.1016/j.chb.2017.10.031

PRISMA 2009 Flow Diagram



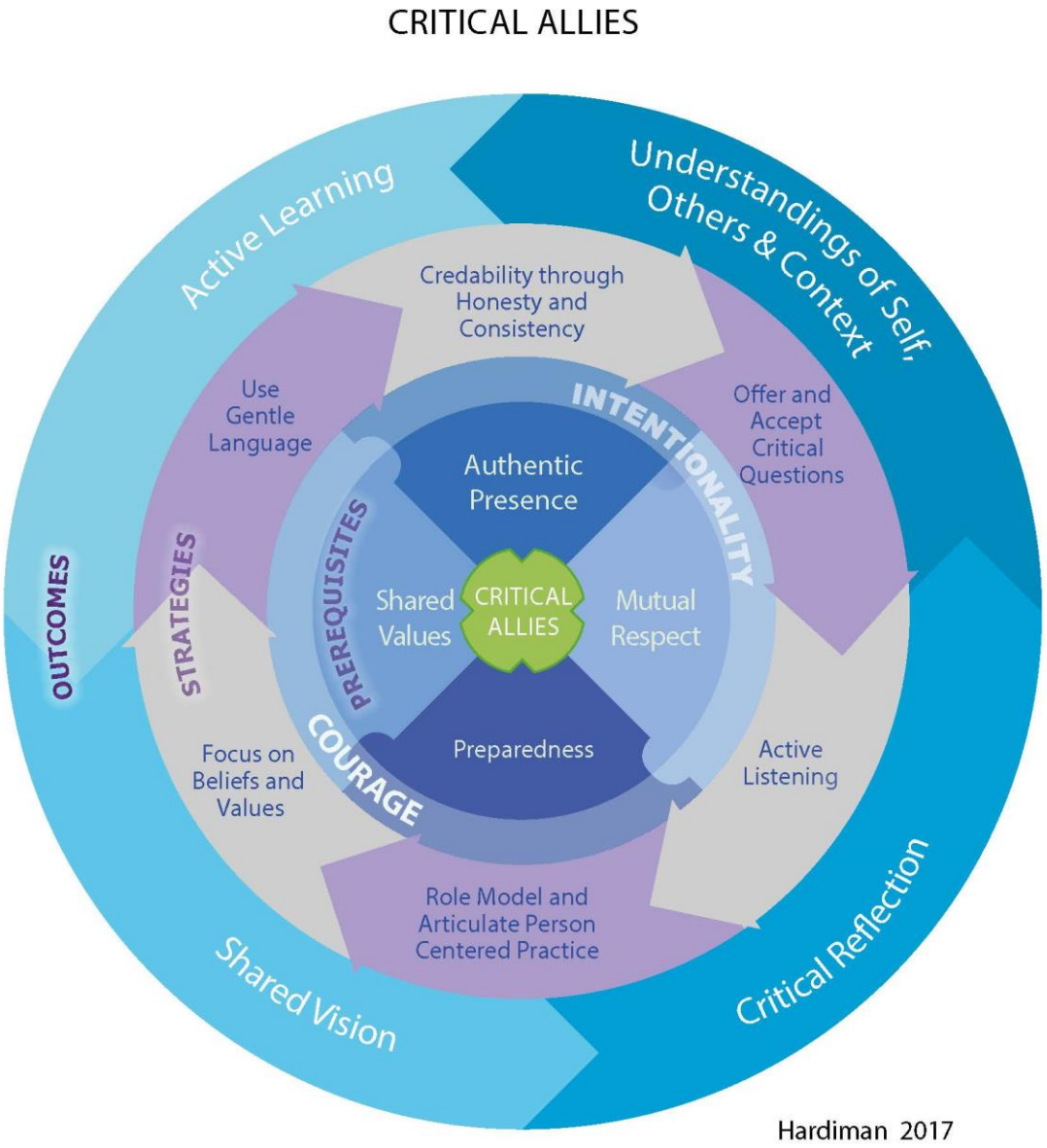
Database	Search Terms	Results
ERIC No limits	**Search 1** – ERIC esu esu(emoji*) AND esu(health) AND esu(education) **Search 2** – anywhere search (emoji*) AND if(health) AND if(education) education **Search 3** – keyword search emoji*) AND if(health) AND if(education) **Search 4** – anywhere search emoji AND health **Search 5** (emoji*) AND if(education) **Search 6** (emoji*) AND if(health)	Nil Nil Nil Nil 1,295,106 Nil
Scopus No limits	**Search 1** – keyword search Emoji and Health and Education	6
Web of Science No limits	**Search 1 -** Title search Emoji and Health and Education	6
Google Scholar Limited to 2010 to 2020	**Search 1** "emoji and "health" and education" **Search 2** "emoji and "health" **Search 3** "emoji" and "learner" and "health" and "tertiary education"	Nil 6,260 24

Year	Author	Title	Study Design / Method	Context	Key statements / findings
2019	Bhattacharya, S., Singh, A., & Marzo, R. R	Delivering emoji/icon-based universal health education messages through smartphones	Discussion paper	Based in healthcare in India	Links emoji to culture; Considers delivering heath messages through using emoji Contends emoji symbols should be used in primary care, current example is in WHO tuberculosis
2016	Donovan, D.P	Mood, emotions and emojis: conversations about health with young people.	Discussion paper	Considers youth mental health services in UK	Using emoji could relieve the pressure answer questions from parents or guardians on feelings and mood. Nurses have a responsibility to keep up to date with trends therefore could be useful for them to work with young people to develop resource for the use of emoji to express mood and feelings Need to consider encouraging the use of internet and mobile devices with vulnerable people could lead to cyber bullying and grooming Practitioners could benefit from training on safeguarding issues related to internet and digital technologies
2017	Fane, J.	Using emoji as a tool to support children's wellbeing from a strength-based approach.	Quantitative study using emoji as a data collection tool	Research on children based in Australia	Children understanding the meanings of emojis Emoji serve as a Strengths based approach used in the classroom - supporting information sharing and finding their own meaning The open ended nature of emoji offers flexibility for its use
2018	Gilles Doiron, J. A.	Emojis: Visual Communication in Higher Education.	Discussion paper	Based in Education in Qatar	Emotions are useful in enabling persons to connect to their emotions and feeling Emojis provide a method for both positive and negative feedback. There is mixed views on the benefits of emoji providing a common language and it is the relationship between sender and receiver that influences the interpretation. Undergraduates are a significant user of emoji on social media. Emoji may be useful in sharing health messages.
2020	Lotfinejad, N., Assadi, R., Aelami, M. H., & Pittet, D.	Emojis in public health and how they might be used for hand hygiene and infection prevention and control.	Discussion paper	Focusses on hand hygiene in Iran and Switzerland	Emoji may be useful in showing behaviours associated with infection prevention and control however limited health related emoji exist Emoji may be useful in bridging the large gap that exist between verbal text based and nonverbal face to face interactions emoji can provide instant feedback potential to provide universal emoji translations for such things as hand hygiene They have the potential to bridge language / translation gap
2018	Troiano, G., & Nante, N.	Emoji: What does the scientific literature say about them?-A new way to communicate in the 21th century.	Systematic literature review	Based in Italy	Emoji could help develop positive doctor / patient relationships Emoji could be classified as non-verbal behaviour very few peer reviewed scientific literature on use of emoji cultural and social factors shape the use of emoji - gender story

2018	Willoughby, J.F., & Liu, S.	Do pictures help tell the story? An experimental test of narrative and emojis in a health text message intervention.	Narrative, Online Experiment,	Computer based research in USA	Credibility of the use of emojis; less emoji more credible however more emojis may lead to increased attention. Likability and recall of messages and increased health outcomes, motivation supported

Appendix H

Critical Allies Framework



Appendix I

UOW School of Nursing Clinical Calendar

2021 School of Nursing Calendar - Autumn Session

Session Week Autumn				O-week	1	2	3	4	5	6	7	Recess	8	9	10	11	12	13	Study Week	Exams 1	Exams 2	Midyear Break	Midyear Break	Midyear Break	Midyear Break
Week starting Monday	1 Feb	8 Feb	15 Feb	22 Feb	1 Mar	8 Mar	15 Mar	22 Mar	29 Mar	5 Apr	12 Apr	19 Apr	26 Apr	3 May	10 May	17 May	24 May	31 May	7 Jun	14 Jun	21 Jun	28 Jun	5 Jul	12 Jul	19 Jul
Year 1																									
All campuses					T1	T2	T3	T4	T5	T6	1st Yr Recess	T7	T8	T9	T10	A	A	B	B	Study Week	Exams	C	C		
Session Week NURS YR 2	1	2	3	4	5	6	7	8	9	10	11	Recess	Recess	12	13	14	15	16	Study Week	Exams 1	Exams 2	Midyear Break	Midyear Break	Midyear Break	Midyear Break
Week starting Monday	1 Feb	8 Feb	15 Feb	22 Feb	1 Mar	8 Mar	15 Mar	22 Mar	29 Mar	5 Apr	12 Apr	19 Apr	26 Apr	3 May	10 May	17 May	24 May	31 May	7 Jun	14 Jun	21 Jun	28 Jun	5 Jul	12 Jul	19 Jul
Year 2																								Spring Session	
All campuses	T1	T2	T3	T4	T5	T6	T7	T8	A	A	A	A	B	B	B	B	T5	T10	Study Week	Exams	Recess	Recess	Recess	T1	T2
Recess												26 Recess	26 Recess												
Year 3																						Spring Session commences			
Session Week NURS YR 3	1	2	3	4	5	6	7	8	9	10	11	Recess	12	13	14	15	16	17	Study Week	Exams 1	Exams 2	Midyear Break	Midyear Break	Midyear Break	Midyear Break
Week starting Monday	1 Feb	8 Feb	15 Feb	22 Feb	1 Mar	8 Mar	15 Mar	22 Mar	29 Mar	5 Apr	12 Apr	19 Apr	26 Apr	3 May	10 May	17 May	24 May	31 May	7 Jun	14 Jun	21 Jun	28 Jun	5 Jul	12 Jul	19 Jul
All campuses	T1	T2	A	A	B	B	T8	T4	T5	T6	T7	2nd Yr Recess	T8	A	A	B	B	T9	OSCA Week	Recess	Recess	T1	T2	A	A

2021 School of Nursing Calendar - Spring Session

Session Week	Midyear Break	Midyear Break	Midyear Break	Midyear Break	1	2	3	4	5	6	7	8	9	Recess	10	11	12	13	Study	Exams 1	Exams 2							MU 1	MU 2	MU 3	MU 4
Week starting Monday	28 Jun	5 Jul	12 Jul	19 Jul	26 Jul	2 Aug	9 Aug	16 Aug	23 Aug	30 Aug	6 Sep	13 Sep	20 Sep	27 Sep	4 Oct	11 Oct	18 Oct	25 Oct	1 Nov	8 Nov	15 Nov	22 Nov	29 Nov	6 Dec	13 Dec	20 Dec	27 Dec	3 Jan	10 Jan	17 Jan	24 Jan
Year 1																															
All campuses	C	C	Recess	Recess	T1	T2	T3	T4	T5	T6	T7	T8	T9	1st Year Recess	T10	A	A	B	B	Study Week	Exams	C	C					1st Yr MU	1st Yr MU	1st Yr MU	
Year 2																															
Session Week NURS Yr 2 Spring	Midyear Break	Midyear Break	1	2	3	4	5	6	7	8	9	Recess	10	11	12	13	14	15	Study	Exams 1								MU 1	MU 2		
Week starting Monday	28 Jun	5 Jul	12 Jul	19 Jul	26 Jul	2 Aug	9 Aug	16 Aug	23 Aug	30 Aug	6 Sep	13 Sep	20 Sep	27 Sep	4 Oct	11 Oct	18 Oct	25 Oct	1 Nov	8 Nov	15 Nov	22 Nov	29 Nov	6 Dec	13 Dec	20 Dec	27 Dec	3 Jan	10 Jan	17 Jan	24 Jan
All campuses	Recess	Recess	T1	T2	T3	T4	T5	T6	T7	T8	T9	2nd Yr Recess	A	A	A	A	T10		Study week	Exam week	B	B	B	B				2nd Yr MU	2nd Yr MU		
Study Recess																															
Session Week NURS Yr 3 Spring	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17											MU 1	MU 2		
Week starting Monday	28 Jun	5 Jul	12 Jul	19 Jul	26 Jul	2 Aug	9 Aug	16 Aug	23 Aug	30 Aug	6 Sep	13 Sep	20 Sep	27 Sep	4 Oct	11 Oct	18 Oct	25 Oct	1 Nov	8 Nov	15 Nov	22 Nov	29 Nov	6 Dec	13 Dec	20 Dec	27 Dec	3 Jan	10 Jan	17 Jan	24 Jan
Year 3																															
All campuses	T1	T2	A	A	A	A	A	B	B	B	B	B	T3	T4	T5	T6	T7	OSCA Week	3rd Yr MU	3rd Yr MU	3rd Yr MU	3rd Yr MU	3rd Yr MU								

Appendix J

Participant Information Sheets – Student and Clinical Supervisor

Research Study - Student

"Crafting person-centred learning relationships for students and clinical supervisors: participatory person-centred research"

Are you a Year 1 Student in the Bachelor of Nursing in the School of Nursing, University of Wollongong, who is available to be allocated a SNUG104 and SNUG108 WPE Placements in May, July or October 2019?

You have been given this information sheet because you are being invited to take part in a research study. This information sheet describes the study and explains what will be involved if you decide to take part.

What is the purpose of this study?

This study is looking to contribute to the international evidence relating to what is known about developing relationships between students and clinical supervisors during a Workplace Experience Placement (WPE Placement) or clinical placement and what person-centred support for students would look like. We are also looking to explore how these relationships may influence your learning during a WPE placement.

Who is conducting the study?

My name is Maria Mackay.

I'm a PhD Candidate at Queen Margaret University and the Director of Clinical Learning at the University of Wollongong. . I am undertaking this research in my capacity as a PhD Student at Queen Margaret University.

What will participating in this project involve?

If you agree to participate in the study, you will be asked to:

- Attend a 1 hour workshop before and after your SNUG104 and SNUG108 WPE placement,
- Use emoji stickers to express the feelings you are experiencing in your WPE placement, take a photo of the emoji
- Participate in an interview on skype / zoom or telephone for 30 minutes at the end of week 1 and week 2 of each of the WPE placements.

- Attend a follow up 1 hour workshop in November 2019.

The discussion in the workshops and interviews will be recorded and written up. This is helpful for me as it means I don't have to take notes during the discussion.

Do I have to take part?

No, it's completely up to you whether or not you take part in the study. If you agree to take part, you will be free to withdraw from the study at any stage, you would not have to give a reason for your withdrawal. Your participation in this study is not a requirement of your enrolment in SNUG104 or SNUG108 at the University of Wollongong, there is no payment for participation, and your decision to participate or not will not affect your enrolment or clinical placement allocation at the University of Wollongong.

What will happen to any information I give?

Any information I have about you and everything you say during the discussion will be kept confidential, this will include your name, students number and UOW email address. Data for the research study will be collected as interviews and creative work. All interviews will be undertaken by the principal researcher and audio-recorded and transcribed, then de-identified for analysis. There is a possibility you may be identifiable from tape recordings of your voice and you will be asked to choose the name used in any quotes we share from the data collected from you.

The researchers will protect your personal information closely so no one will be able to connect your responses and any other information that identifies you. Federal or state laws in Scotland may require us to show information to university or government officials, who are responsible for monitoring the safety of this study. Directly identifying information (e.g. names, student numbers and UOW emails) will be safeguarded and maintained under controlled conditions.

We will ask you and others in the group not to talk to people outside the group about what was said during the discussion. All electronic data will be stored on a password protected computer. Any paper copies will be kept in a locked filing cabinet. All digital recordings will be destroyed after completion of the project. Other data from the study will be retained, in a secure location.

What will happen to the results of the project?

The results of the research will be published in a PhD thesis, an international peer reviewed journal or presented at conferences or similar events. You will not be identified in any publication from this study.

What are the possible benefits of taking part?

There will be no immediate benefits for you, but by taking in part in this study you can help us better understand how student and clinical supervisors develop relationships in clinical practice and the impact this may have on transformative learning for both groups. You will also be contributing to the development of learning and teaching

resources that will be used within the Bachelor of Nursing at the University of Wollongong.

Are there any risks?

There is a risk that you may learn something about yourself that you were unaware of and this may cause you some emotional upset. In which case, you can pause whatever activity you are engaged in or you can elect to withdraw from the research at any time. Counselling services are available at UOW are confidential and free of charge if you wish to use these.

Contact details

I am the main contact for the study. If you have any questions about the project, please don't hesitate to ask. My contact details are:

Name of researcher:	Maria Mackay
Address:	School of Nursing | SMAH | Rm G16,
	Batemans Bay Campus
	'Hanging Rock', Beach Road,
	University of Wollongong Batemans Bay NSW 2536
Email / Telephone:	mmackay@uow.edu.au / 0407369627

If you would like to contact a local independent person, who knows about this project but is not involved in it, you are welcome to contact Dr Rebekah Middleton. Her contact details are:

Name of adviser:	Dr Rebekkah Middleton
	Senior Lecturer; BN Academic Program Director; L&T Scholar
Address:	School of Nursing | SMAH | 41.221
	University of Wollongong NSW 2522 Australia
Email / Telephone:	rmiddle@uow.edu.au / 42213724

Project team:

Maria Mackay, Queen Margaret University Edinburgh and University of Wollongong
Professor Jan Dewing, Queen Margaret University Edinburgh
Dr Anne Williams, Queen Margaret University Edinburgh
Dr Sharon Bourgeois, University of Wollongong

This study has been reviewed by the Human Research Ethics Committees at Queen Margaret University and the University of Wollongong, Ref. 2019/237. If you have any concerns or complaints about the conduct of this research please contact either my research supervisor Professor Jan Dewing, who is the Sue Pembrey Chair at QMU in Edinburgh on email jdewing@qmu.ac.uk or the Ethics Manager on 02 4221 4457 or email rso-ethics@uow.edu.au.

There has been no funding provided by any source for this research study to be undertaken.

Thank you for considering taking part in this study and taking the time to read this information. If you are willing take part in this research study please contact Carley Jans on cjans@uow.edu.au and she will forward you a consent form for you to complete.

Research Study - Clinical Supervisor

"Crafting person-centred learning relationships for students and clinical supervisors: participatory person-centred research"

Are you a Clinical Supervisor who is employed by the University of Wollongong in the School of Nursing who is available to be allocated work during the SNUG104 and SNUG108 WPE Placements in May, July and October 2019?

You have been given this information sheet because you are being invited to take part in a research study. This information sheet describes the study and explains what will be involved if you decide to take part.

What is the purpose of this study?

This study is looking to contribute to the international evidence relating to what is known about developing relationships between students and clinical supervisors during a Workplace Experience Placement (WPE Placement) or clinical placement and what person-centred support for students would look like. We are also looking to explore how these relationships may influence your learning during a WPE placement.

Who is conducting the study?

My name is Maria Mackay.

I'm a PhD Candidate at Queen Margaret University and the Director of Clinical Learning at the University of Wollongong. I am undertaking this research in my capacity as a PhD Student at Queen Margaret University.

What will participating in this project involve?

If you agree to participate in the study, you will be asked to:

- Attend a 1 hour workshop before and after your SNUG104 and SNUG108 WPE placement,
- Use emoji stickers to express the feelings you are experiencing in your WPE placement, take a photo of the emoji
- Participate in an interview on skype / zoom or telephone for 30 minutes at the end of week 1 and week 2 of each of the WPE placements.
- Attend a follow up 1 hour workshop in November 2019.

The discussion in the workshops and interviews will be recorded and written up. This is helpful for me as it means I don't have to take notes during the discussion.

Do I have to take part?

No, it's completely up to you whether or not you take part in the study. If you agree to take part, you will be free to withdraw from the study at any stage, you would not have to give a reason for your withdrawal and it will have no implications for your employment or placement allocations. Your participation in this study is not a requirement of your employment as a casual academic at the University of Wollongong, there is no payment for participation, and your decision to participate or not will not affect your employment at the University of Wollongong.

What will happen to any information I give?

Any information I have about you and everything you say during the discussion will be kept confidential, this will include your name, students number and UOW email address. Data for the research study will be collected as interviews and creative work. All interviews will be undertaken by the principal researcher and audio-recorded and transcribed, then de-identified for analysis. There is a possibility you may be identifiable from tape recordings of your voice and you will be asked to choose the name used in any quotes we share from the data collected from you.

The researchers will protect your personal information closely so no one will be able to connect your responses and any other information that identifies you. Federal or state laws in Scotland may require us to show information to university or government officials, who are responsible for monitoring the safety of this study. Directly identifying information (e.g. names, student numbers and UOW emails) will be safeguarded and maintained under controlled conditions.

We will ask you and others in the group not to talk to people outside the group about what was said during the discussion. All electronic data will be stored on a password protected computer. Any paper copies will be kept in a locked filing cabinet. All digital recordings will be destroyed after completion of the project. Other data from the study will be retained, in a secure location.

What will happen to the results of the project?

The results of the research will be published in a PhD thesis, an international peer reviewed journal or presented at conferences or similar events. You will not be identified in any publication from this study.

What are the possible benefits of taking part?

There will be no immediate benefits for you, but by taking in part in this study you can help us better understand how student and clinical supervisors develop relationships in clinical practice and the impact this may have on transformative learning for both groups. You will also be contributing to the development of learning and teaching resources that will be used within the Bachelor of Nursing at the University of Wollongong.

Are there any risks?

There is a risk that you may learn something about yourself that you were unaware of and this may cause you some emotional upset. In which case, you can pause whatever

activity you are engaged in or you can elect to withdraw from the research at any time. Counselling services are available at UOW are confidential and free of charge if you wish to use these.

Contact details

I am the main contact for the study. If you have any questions about the project, please don't hesitate to ask. My contact details are:

Name of researcher:	Maria Mackay
Address:	School of Nursing | SMAH | Rm G16,
	Batemans Bay Campus
	'Hanging Rock', Beach Road,
	University of Wollongong Batemans Bay NSW 2536
Email / Telephone:	mmackay@uow.edu.au / 0407369627

If you would like to contact a local independent person, who knows about this project but is not involved in it, you are welcome to contact Dr Rebekah Middleton. Her contact details are:

Name of adviser:	Dr Rebekkah Middleton
	Senior Lecturer; BN Academic Program Director; L&T Scholar
Address:	School of Nursing | SMAH | 41.221
	University of Wollongong NSW 2522 Australia
Email / Telephone:	rmiddle@uow.edu.au / 42213724

Project team:

Maria Mackay, Queen Margaret University Edinburgh and University of Wollongong
Professor Jan Dewing, Queen Margaret University Edinburgh
Dr Anne Williams, Queen Margaret University Edinburgh
Dr Sharon Bourgeois, University of Wollongong

This study has been reviewed by the Human Research Ethics Committees at Queen Margaret University and the University of Wollongong, Ref. 2019/237. If you have any concerns or complaints about the conduct of this research please contact either my research supervisor Professor Jan Dewing, who is the Sue Pembrey Chair at QMU in Edinburgh on email jdewing@qmu.ac.uk or the Ethics Manager on 02 4221 4457 or email rso-ethics@uow.edu.au.

There has been no funding provided by any source for this research study to be undertaken.

Thank you for considering taking part in this study and taking the time to read this information. If you are willing take part in this research study please contact

Carley Jans on cjans@uow.edu.au and she will forward you a consent form for you to complete.

Appendix K

Consent Form

Consent Form template version 1.0 20151222

Queen Margaret University
EDINBURGH

Participant Identification Number for this project:

CONSENT FORM

Title of Project: Crafting person-centred learning relationships for student learners and clinical supervisor learners: participatory person-centred research

Name of Researcher: Maria Mackay

Please tick all relevant boxes to indicate your consent. You may consent to all of the purposes, any number of the purposes or none of the purposes. If you do not consent to using your information for the purposes listed below then you will not be contacted.

	Please initial box
1. I confirm that I have read and understand the information sheet provided for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researchers involved and withdraw from it immediately without giving any reason. Furthermore, I understand that I will be able to withdraw my data up to two to four weeks after the interview.	☐
3. I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the UK Data Protection Act 2018. This information will include my name, student number, UOW email address and my twitter handle (if applicable).	☐
4. If I have a twitter handle, I consent to share my details of this and my name on social media, this includes twitter, UOW Nursing Blog and QMU Nursing Blog	☐
5. I consent to the digital audio-recording of the workshops and my interview. I understand that this will be destroyed as soon as the interview has been transcribed and anonymised	☐
6. I understand that any personal data that could be used to identify me will be removed from the transcripts and that I will not be identified in any publications, reports or presentations.	☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Thank you for agreeing to participate

Please complete this form and return to cjans@uow.edu.au

Appendix 2_Consent form – when completed please email to mmackay@uow.edu.au

Appendix L

Overview of Research Workshops

Part One

Planning Meeting Overview

Following the introduction workshop and prior to the WPE placement, those participants who express an interest in being co-researchers will be invited to a planning workshop. There will be one meeting that includes both students and clinical supervisors. The meeting is planned for 1 hour.

1. Introductions and welcome
2. Overview of the role of co-researcher will be explained and explored by the group
3. An A5 representation of the research study design will be on display for the co-researchers to consider.
4. Participants will consider the process and how this could be best implemented with each group, both students and clinical supervisors. This exercise will be undertaken with the study design in A5 size and with participants placing posit it notes on study design.
5. The principal researcher will facilitate a conversation where the participants can share their feedback. A summary of the feedback will be recorded on a white board and there will be an opportunity for the participants to validate the summary.
6. At the end of the workshop, the researcher will provide a closure to their participation in the research study and information on the dissemination of the findings.

Analysis Meeting Overview

Following the workshop 2 and prior to the SNUG108 WPE placement, co-researchers will be invited to an analysis workshop in separate groups (student and clinical supervisors). This workshop is to provide an opportunity to bring together all learning from the research study to date with regard to the supervisory relationship from each group .The workshop will be run similar to the initial analysis workshop however, the aim will be to synthesise all information and to seek clarification of information collected to date

1. Introductions and welcome
2. A poster of all of the emoji stickers collected will be on the wall
3. A summary of the analysis workshops with each group will be provided.
4. Following this, participants will be encouraged to sit quietly and listen to the thoughts that come into their minds related to supervisory relationships, they will then complete a creative representation of these thoughts.

5. The collection of creative representations will be considered by the group and the participants will consider what they see; feel and experience when they look at this. The words and phrases they use will be captured as part of the workshop.
6. The final stage of the workshop will be to consider the overall learning from each group.
7. The close of the workshop will consider how this learning will translate to the SNUG108 WPE placement.

Part Two

Analysis Meeting Overview

Following the completion of Part Two workshops, co-researchers in separate groups will be invited to an analysis workshop. This workshop is to provide an opportunity to bring all learning from the research study to date. It will be run similar to the Analysis Workshop in Part One however, the aim will be to synthesise all information and learnings to date.

1. Introductions and welcome
2. Information gathered from the research to date will be on display in the room
3. A summary of the themes that have emerged to date will be provided.
4. Following this participants will be encouraged to sit quietly and listen to the thoughts that come into their minds related to supervisory relationships. They will then complete a creative representation of these thoughts
5. The collection of creative representations will be considered by the group and the participants will consider what they see; feel and experience when they look at this. The words and phrases they use will be captured as part of the workshop.
6. The final stage of the workshop will be to consider the learnings to date from each group separately - students and clinical supervisors.
7. The close of the workshop will be to invite the co-researchers to be involved in the dissemination of the research findings.

Appendix M

Emoji information collection form - sample Day 1

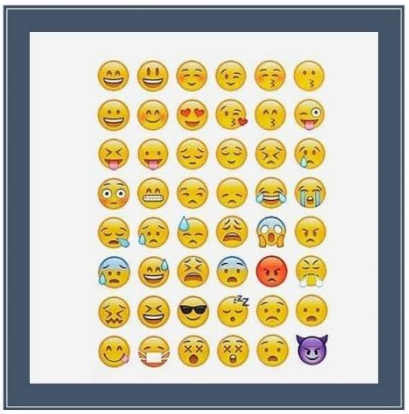
Please indicate on the sticker page below with a circle on the positive feelings and the challenging feelings for the questions below

Consider your relationship you have with your student/s today,

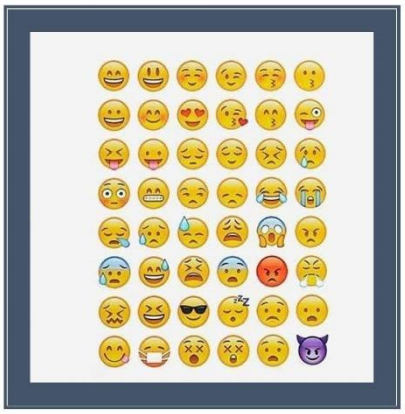
Firstly - What was a positive feeling or emotion you had in your relationship with your student/ s today? Circle to indicate the emoji

Secondly - What was a challenging feeling or emotion you had in your relationship with your student/s today? Circle to indicate the emoji

Week 1 - Day 1 – Positive emotion/s



Day 1 – Challenging emotion/s



Consider any examples of positive emotions _____

Consider any examples of challenging emotions

_____

_____

2

Phase 1 – emoji collection sheet SNUG108

Appendix N

Recruitment Email for participants in part one – example for student and clinical supervisor

Student

You are receiving this email as a Student in the Bachelor of Nursing at the University of Wollongong.

All the other Students allocated in SNUG108 Pattern A will also receive this email. Maria Mackay, is undertaking this research as part of her PhD, she is also the Director of Clinical Learning in the School of Nursing, UOW. You are invited to participate in a research project that aims to consider the development of healthful relationships between student and clinical supervisor. You are invited to join Maria in this project as a participant.

If you choose to participate we would ask you to take part for approximately a total of 3 hours and 40 minutes during Spring session. There will be 3 workshops you will be asked to attend and all workshops will be with students only. Other participants, the clinical supervisors will meet as a separate group. The first workshop will be an introduction, the second and third workshop will be an opportunity to participate in the shared learning with the other participants after each WPE placement. In addition to this you will be asked to collect information each day for approximately 10 minutes during your WPE placement or clinical placement. During your WPE placement you will be asked to use Emoji stickers to collect your feeling and memories of your supervisory relationship and to record a photo of these emoji each day . You will participate in a 30 minute interview following week 1 and week 2 of your WPE placement that summarises the stickers you have collected. All interviews will be undertaken by the principal researcher and audio-recorded and transcribed, then de-identified for analysis.

Your participation in this study is not a requirement of your employment at the University of Wollongong, there is no payment for participation, and your decision to participate or not will not affect your enrolment or clinical placement allocation at the University of Wollongong.

Included within this email is a participant information sheet with more details of the research study that will provide you further information and allow you to further consider your participation in this research. If you would like to take part in the research study please reply to this email on cjans@uow.edu.au and you will be sent a consent form via email for you to complete.
In the meantime if you would prefer to talk to someone about the project please contact: Carly Jans on 42213219 or email cjans@uow.edu.au or Maria Mackay Principal Researcher on ph.0407369627 or email mmackay@uow.edu.au .

Carley Jans
Lecturer – School of Nursing

Clinical Supervisor

You are receiving this email as a clinical supervisor in the Bachelor of Nursing at the University of Wollongong.

All the other clinical supervisors who are allocated to work in SNUG108 Pattern A will also receive this email. Maria Mackay, is undertaking this research as part of her PhD, she is also the Director of Clinical Learning in the School of Nursing, UOW. You are invited to participate in a research project that aims to consider the development of healthful relationships between student and clinical supervisor. You are invited to join Maria in this project as a participant.

If you choose to participate we would ask you to take part for approximately a total of 3 hours and 40 minutes during Spring session. There will be 3 workshops you will be asked to attend and all workshops will be with students only. Other participants,

the students will meet as a separate group. The first workshop will be an introduction, the second and third workshop will be an opportunity to participate in the shared learning with the other participants after each WPE placement. In addition to this you will be asked to collect information each day for approximately 10 minutes during your WPE placement or clinical placement. During your WPE placement you will be asked to use Emoji stickers to collect your feeling and memories of your supervisory relationship and to record a photo of these emoji each day . You will participate in a 30 minute interview following week 1 and week 2 of your WPE placement that summarises the stickers you have collected. All interviews will be undertaken by the principal researcher and audio-recorded and transcribed, then de-identified for analysis.

Your participation in this study is not a requirement of your employment at the University of Wollongong, there is no payment for participation, and your decision to participate or not will not affect your employment or clinical placement allocation at the University of Wollongong.

Included within this email is a participant information sheet with more details of the research study that will provide you further information and allow you to further consider your participation in this research. If you would like to take part in the research study please reply to this email on cjans@uow.edu.au and you will be sent a consent form via email for you to complete.
In the meantime if you would prefer to talk to someone about the project please contact: Carly Jans on 42213219 or email cjans@uow.edu.au or Maria Mackay Principal Researcher on ph.0407369627 or email mmackay@uow.edu.au .

Carley Jans
Lecturer – School of Nursing

Appendix O

Recruitment Email for co-researchers in part one - sample

Thank you for participating in the information collection for the emoji information collection.

You are receiving this email to invite you to attend a workshop to make sense of the information that was collected in the interviews following the clinical plamcents in SNUG108.

All the other students / clinical supervisors who are allocated to work in SNUG108 Pattern A will also receive this email. If you choose to participate as a co-researcher we would ask you to take part for approximately a total of 2 hour workshop that will be facilaited by Maria Mackay as the principal researcher and one other academic staff member. You will be asked to review the information collected prior to the workshop. During the workshop we will be using creative methods to help you make sense of the interview transcripts.

Your participation in this study is not a requirement of your enrolment / employment at the University of Wollongong, there is no payment for participation, and your decision to participate or not will not affect your enrolment / employment or clinical placement allocation at the University of Wollongong.

Included within this email is a participant information sheet to remind you of the research project and give you more details of the research study that will provide you further information and allow you to further consider your participation as a co-researcher in this research. If you would like to take part in the research study please reply to this email on cjans@uow.edu.au and you will be sent a consent form via email for you to complete.

In the meantime if you would prefer to talk to someone about the project please

contact: Carly Jans on 42213219 or email cjans@uow.edu.au or Maria Mackay Principal Researcher on ph.0407369627 or email mmackay@uow.edu.au .

Carley Jans
Lecturer – School of Nursing

Appendix P

Research Protocol

Research protocol – Crafting person-centred learning relationships in clinical practice

Study Title: Crafting person-centred learning relationships for students and clinical supervisors: participatory person-centred research

Background

This research study seeks provide evidence on the development of healthful relationships in the context of education in a non-classroom setting. There is currently limited evidence on what constitutes a healthful relationship and this to date has not been explored in the context of a clinical supervision relationship between a student and clinical supervisor in clinical practice. As mentioned in the summary healthful relationship is one where a relationship between two or more people is built on trust, mutual respect and shared decision making (McCormack and McCance 2017). This research study will inform what this relationship may look like, feel like and what would be experienced if healthful relationships are achieved. It is hoped it will also inform the impact of healthful relationships on the learning of both student and clinical supervisors. An assumption within this research is that there are positive and negative aspects to the relationship that is created between student and clinical supervisors. The focus on this research will be to learn from reflecting on and analysing when relationships are developed that students or clinical supervisors report to be healthful. It is also assumed that there may be learning from reflecting on and analysing when relationships are developed that students or clinical supervisors report not to be healthful.

This research study forms the final phase of a PhD research project. Two previous approved research studies have informed the development of this proposal, these include firstly a research study on effective strategies for clinical supervisor education and secondly a study on a student led conversation with their clinical supervisors

during their clinical placement. Conclusions made from the first study were that evidence-based education for registered nurses in the specific role of clinical supervisor is limited at both a national and an international level. The literature review conducted for this study supported that education should be relevant to the requirements of the role, be across several modalities and that the clinical supervisors should be involved in the design and delivery of this education. Further, the literature demonstrated that there was limited information on what should be included as learning and teaching resources. Future educational strategies need to consider that the registered nurses who work at the bedside with students play a pivotal role in their clinical learning (Mackay, Dewing and Riley, in press 2019). The second study focused on students and revealed the assumption that they are prepared for the technical aspects of clinical practice however, it is the emotional challenges that come with the changeable and diverse environment that clinical practice is, that students are not prepared for. The student group who participated in the study also reported that they believed that by showing their vulnerability, they were more able to connect with their clinical supervisor on a human level. This finding is particularly relevant to this research study as these findings are supported by other authors (Levett-Jones and Lathlean 2007) that is, the relationship between a student and their supervisor has a significant impact on both their learning and their overall experience during clinical placement.

Clinical placement is a prescribed component of the Bachelor of Nursing Program in Australia and is referred to in the literature in various ways such as, workplace experience, work integrated learning, clinical placement. Students enrolled in a Bachelor of Nursing program in Australia must meet a minimum of 800 hours in the clinical practice environment to be eligible to register as nurse on the completion of their degree (ANMAC 2012). The registered nurse accreditation standards states that all students must be supervised and assessed by a registered nurse during their clinical placement (ANMAC 2012, p.18).

On the other hand, clinical practice is a broad term to identify the practice of, in this case, nurses, and students are placed into the clinical practice environment to meet accreditation standards.

The topic of this PhD research study is based on the four significant issues that are of emerging international importance. Firstly, there is no agreed model for the supervision of students undertaking a Bachelor of Nursing (BN) during their clinical placements within Australia or internationally. Secondly, there is a lack of evidence on what constitutes a meaningful (or healthful as used in this research study) relationship between students and clinical supervisors during a clinical placement. There is however a strong evidence base that it is the supervisory relationship that enables a sense of belonging for students resulting in them being motivated and more able to learn (Levett-Jones and Lathlean 2007; Levet-Jones et al. 2009; Vinales 2015). Further, there is limited evidence of how to prepare clinical students and supervisor leaners to develop a supervisory relationship (Giddens & Eddy 2009; Mckinnon 2009; ANMAC 2012; Mackay et al. 2014). Finally, a literature review revealed no evidence on how fostering of healthful relationships between clinical supervisors and students can enable person-centred transformative learning experiences in clinical practice for students enrolled in a Bachelor of Nursing program. Thus, the following research question is proposed.

Research Question

"How do healthful relationships between clinical supervisors and students influence transformational learning?"

Aims and Objectives

This research has four aims: (1) Understand what a healthful relationship between students and clinical supervisors looks like and feels like; (2) Explore the experience of clinical supervisors who develop healthful relationships with students in clinical practice; (3) Explore the experience of students who are supervised in clinical practice by clinical supervisors where healthful relationships exist and (4) Explore if healthful relationships between students and clinical supervisors influence person-centred transformative learning cultures in clinical practice.

The objectives in this study are to: (1) Contribute to the person-centred knowledge

base about the preparation of clinical practice, specifically the development of healthful relationships and person-centred culture; (2) Contribute to the person-centred knowledge base, specifically about the development of person-centred education curricula at UoW, and wider in Australia and (3) Contribute to the person-centred transformational learning knowledge base specifically within a clinical non classroom setting.

Methodology

This research study will draw on a number of necessary and complementary theoretical underpinnings in participatory person-centred research methodology. Methodology is defined by Cohen et al. (2018, p. 53) as:

> "…((how we research complex, multiple realities): influenced by communities of practice which define what counts as acceptable ways of researching, and which mixed methods can feature, as they enable qualitative dialogue to be established between the participants in the research."

The above definition is derived from an educational perspective and has a broader application as it comes from a critical realist ontological perspective where multiple realties are accepted. This relates to the ontological perspective this research study will be taking, that is a person-centred (McCormack et al. 2017) and a critical realist (Bhaskar and Hartwig 2010) perspective where ontology comes before methodology and as researchers and participants we need to be clear on our values and how they are being represented within this research. The emphasis in the definition on complexity is also relevant as both the educational and healthcare environments on their own are complex with complexity increasing significantly once they collide in the theory and practice divide of university education and clinical practice.

This research study proposes to facilitate the creation of person-centred safe spaces that enable clinical supervisors and undergraduate nursing students to empower themselves as participants in the development of transformative person-centred learning cultures. The creation of safe spaces is drawn from Habermass' Theory of Communicative Spaces. This theory originated from Habermas (1981) and has been defined by Bevan (2013, p. 14) in the action orientated research space as the creation of safe spaces for participants to come together and discuss a common issue and to

"have their voices heard". McCormack et al. (2011) describe a person-centred learning culture in the clinical practice environment to be one where "nurses view their work as exciting and revitalising, offering them the prospect for both personal and professional growth". (Page No) The research will explore how the fostering of healthful relationships between clinical supervisors and students can enable transformative person-centred learning experiences in clinical practice. Healthful relationships in this context are evident when decision making is shared, staff relationships are collaborative, leadership is transformative and innovative practices are supported. Overall, evidence supports it is the relationship between the clinical supervisor and the student that creates the feelings of belonging.

Participatory person-centred research methods fits with this research study due to the three underlying principles it espouses. They include, that its purpose is to "enable action" that is reflective and participant driven, it acknowledges power and aims to share this equally across the "researcher and the researched" and finally it passively collects data and information by appreciating the "vulnerability of the participants" and including them as co-researchers (Baum et al. 2006, p. 854; McNiff and Whitehead 2011). More broadly, this research study espouses the following methodological principles that will guide all aspects of the research process:

- The people who participate in this research have innately within their ability to flourish to their full potential as both participants and co-researchers.
- The people who participate in this research have the right to authentically participate in this research in the way that is right for them and they maintain the power to change their contribution at any point within the research process.
- The people who participate in this research have the courage and curiosity to explore the layers of the relationships they develop during a clinical placement considering how this impacts on their ability to realise human flourishing.
- That all turbulence in clinical practice has the potential to transform into purposeful turbulence enabling students and clinical supervisors to realise true belonging and transformative learning.

- That reflexivity is embedded into the Knowing, Doing And Being as a participant and co-researcher in this research study.

The above methodological principles are represented in the model below:

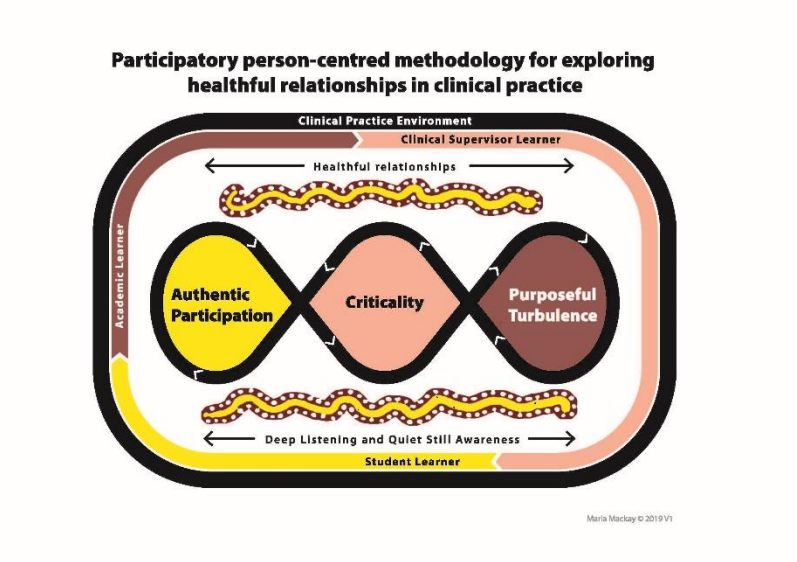


Image 1: Participatory person-centred methodology for exploring relationships in clinical practice

The above design brings together the principles of participatory and person-centred research in the development of healthful relationships through the consideration of authentic participation, criticality and purposeful turbulence. These are entwined further within the Australian Aboriginal concept of Didirri, which is deep listening and quiet still awareness. This concept is described in a poem by Aunty Miriam-Rose Ungunmerr (1988), an Australian Aboriginal woman and has been used to explore an approach to research, where one takes the time to sit quietly and listen deeply to people to contemplate the meaning they share with us and create meaningful learning (purposeful) in the complexity or turbulence of clinical practice.

Study Design

This research study will occur over two academic sessions, across a total data collection time of 9-12 months (see appendix 4). Part One of the research study involves participants reflecting on their feelings and experiences during the 3 months following a pre-planned academic subject clinical placement (pattern A and B). This clinical placement is a two week placement that will occur in both July and October 2019. Undertaking this part of the research study will allow the principal researcher

and co-researchers to understand the elements of a healthful relationship between students and clinical supervisors. Part Two of the research study will explore how healthful relationships between clinical supervisors and students influence person-centred transformational learning for both students and clinical supervisors during workshops (appendix 5) that will be undertaken at the University of Wollongong in Australia at the completion of each academic session. Consistent with the principles of participatory and person-centred research, all participants will be invited to have a role as a co-researcher.

Part One (July and October):

In this part of the research, the students and clinical supervisors will be in separate groups. Within their separate groups (student learners and clinical supervisor learners), the participants will be invited to attend an introduction workshop (appendix 5) that will provide information regarding the research study and to consider their understanding of a healthful relationship. I propose that as individuals, each participant will use creative means such as emoji stickers and cards to collect their feelings and experiences each day. I will then interview all participants at the end of week 1 and week 2 of each of the clinical placements to gather information that summarises their experiences and feelings. Undertaking this phase of the research will enable the participants and myself to gain an understanding of the elements of relationship that is Healthful for both the student learners and clinical supervisor learners.

Part Two (July and Dec)

Part Two will be undertaken at the University of Wollongong, Australia. The focus will be on exploring what we have revealed in Part One and aims to further develop an understanding of "How do healthful relationships between clinical supervisor learners and student learners influence transformational learning?" This part will be completed after each academic session with the group of participants and concludes each section of the data gathering process. The student learners and clinical supervisor learners will be separate groups and will participate in a face-to-face workshop (appendix 5) following the clinical placement. I propose that each participant will

participate in a half-day workshop (appendix 5) on two occasions, one at the end of each academic session. These will be held after the exam period so as not to cause any undue stress or inconvenience for the student learner participants. Learnings from Part One and from participating in the learning and teaching component of the academic session will be considered alongside the theoretical model developed as part of this PhD research study, A Model for Person-Centred Transformational Learning in Clinical Practice.

The overall time commitment for the participants is 3 hours and 40 minutes.

Co-researchers

All participants will have the opportunity to be involved as co-researchers in the research study. In keeping with the principles of participatory and person-centred research, co-researchers should be involved in all aspects of the research including development, implementation, evaluation and dissemination of the findings with the research study. The additional role of co-researcher will be a time commitment of 6 hours, this includes being a participant in the research and the additional workshops (appendix 5) for co-researchers. Co-researchers will also have the opportunity at any time to change their role back to being a participant only. The role of a co-researcher will include participating in three, 2 hour sessions, one before each of the two academic sessions and one at the end of the research study for analysis and evaluation.

Participants

I intend to aim for 6-10 participants in each group, one group will be student learners and the other will be clinical supervisor learners as this study is seeking to identify the perspective of this group and to learn from their experience. This PhD research study situates within a critical realist paradigm and the intent of the study is not to look for saturation or generalisability rather the intent is informing the future practice of a certain community. It is expected there will be learnings that will inform future practice.

To be considered to participate in this research:

Student Learners must:

- Be enrolled in year 1 of the Bachelor of Nursing at UOW in 2019 Be eligible for a clinical placement in academic subjects SNUG104 and SNUG108 Pattern A and B
- Be willing to undertake the requirements of the reflections and one workshop prior to their placement and one workshop at the end of their placement period in person at Wollongong Campus.

Clinical Supervisor Learners must:

- Be employed as a casual clinical facilitator with UOW School of Nursing
- Be available for allocation of work in academic subjects SNUG104 and SNUG108 Pattern A and B
- Be willing to undertake the requirements of the reflections and one workshop prior to their placement and one workshop at the end of their placement period in person to be held at Wollongong Campus.

There is no set exclusion criteria for either group. For the student learners the exclusion is their pattern allocation, that is, students in Pattern C undertake their clinical placement on a different date and therefore are not eligible to participate. For the clinical supervisor learners their exclusion is them being allocated to supervise students in Pattern A and B. Those not allocated in this date range are therefore excluded.

Recruitment

For both of the groups, student learners and clinical supervisor leaners, the initial contact for recruitment will be with an independent person (Carley Jans who is the Deputy Director of Clinical Learning and not a part of this research study) to reduce any feeling of pressure to take part. I will recruit potential participants through the recruiter (Carely Jans) sending an email (appendix 3) to clinical supervisor learners and student learners, inviting them to participate and providing them with an overview of the research study. Potential participants can phone or email the recruiter to access further verbal and written information. I will provide the recruiter with a crib sheet of information to refer to. The recruiter will pass on my contact details (phone and email) to enable any potential participants to establish contact with me. I will have an initial

introductory conversation or email with the potential participant in which I will outline the study and what is being requested of participants. With their permission, I will send them a written Participant Information Sheet and Consent Form (see appendices 1a and 1b). This will provide clear information about the right to not take part or to withdraw and matters relating to confidentiality. There will be a clear message that there will be no negative consequences and no discrimination if they choose to participate or choose not to participate in the research study. Following this, potential participants will be able to ask further questions and sign and return the consent form (appendix 1b) via email to me.

Data collection

The data collected within this research study will be in three sections, introduction and orientation Part One and Part Two. The three sections will be the same for both groups (student learners and clinical supervisor learners) and facilitated by myself as principal researcher in collaboration with the participants who elect to be co-researchers.

Introduction and Orientation– All participants will be invited to attend one of two introduction sessions, one for clinical supervisor learners and one for student learners. In these sessions, introductions will take place and participants will be given information about the research study. This enables participants to confirm or revisit their consent. The sessions will focus on the establishment of ways of working, followed by a group exploration of what a healthful relationship between a clinical supervisor learner and student learner would ideally look like and feel like according to evidence.

Part One – exploring what the elements of a healthful relationship between clinical supervisor learners and student learners in clinical practice. This orientation will be undertaken over a 10-day clinical placement in July and October 2019. The fieldwork with data collection will be organised to fit in with UOW School of Nursing pre-planned clinical placements associated with academic subjects. Therefore, no participant will be affected in the timing of his or her planned clinical placement by the research study. The focus of Part One will be to consider the connection between

true belonging and memory making. Student learners and clinical supervisor learners will consider the memories that were made for them as a result of their relationship.

The methods will include:

- An exploration through the use of emoji cards and stickers to collect perceptions of the healthful relationship from both a student learner and clinical supervisor learner during a clinical placement
    - Each participant will be given a set of emoji cards and stickers including a range of facial expressions.
    - Each participant will use the emoji by selecting at least one after each day to reflect how they experienced
- The principal researcher will organise a Zoom / Skype interview outside of the clinical practice time to meet with participants separately after each week of their clinical placement to discuss their supervision relationships. Participants are to take a photograph at the end of each week of their emoji journal and send this to the principal researcher.
- In these meetings the participant will reflect on the emoji they have collected. They will reflect on the positive memories that were made that week and the challenging memories that were made.
- These reflective memories will be explored further using a mirror image at the end of the meeting. For example: If they looked into a mirror, what would it say given the last weeks experience. Mirror, Mirror on the wall, what is the best supervision relationship of them all?
- The interviews will be taped and transcribed.
- This process will be repeated at the end of week 2.

Part Two – Exploring "How do healthful relationships between clinical supervisor learners and student learners influence transformational learning?" This part will be undertaken after each academic session as a face-to-face group discussion, and then as a way of concluding the research process. The approach taken at these sessions is detailed below:

- Following the clinical placement, there will be a separate face-to-face workshop with the student learners and clinical supervisor learners. This workshop will include an exploration of the influence of the supervisory relationship on the 'Person-Centred Transformational Learning in Clinical Practice' (see Image 1) where each participant group considers the model of Person-Centred Transformational Learning and provides a collective reflection on the relationship between the recent theoretical and clinical placement components they have experienced in the academic session.
- This reflection will begin with an individual creative representation from their perspective of Knowing, Doing, Being and Becoming.
- The group will come together and share their individual representation to create an overall collage of Knowing, Being, Doing and Becoming, true belonging, critical reflection and critical dialogue.
- Participants will then share what they see, feel and experience when looking at the collage.
- A discussion on relationship focusing on' what is already captured in the proposed model' and 'what is missing' will be undertaken.
- This discussion will be recorded and transcribed
- The outcomes will inform the development and / or adjustment of subject content and assessment.
- The final part of the workshop will be a closing of the research process for that academic session.

At the end of the academic session 1 (Autumn) participants and co-researchers will be able to choose to return for the next academics session 2 (Spring) or complete their involvement in the research study. This choice will be undertaken online to minimise any feelings participants may have of coercion.

Ethical considerations

The main ethical consideration for this research study is to ensure that student learners will be able to address any concerns relating to their role as student learner participants of UOW. In particular we anticipate that some student learner participants may feel

they need to participate in the project as a way of ensuring educational support and/or progression within their program. Student learner participants in this project have a relationship with the principal researcher from this research study. The relationship is both a formal teaching role and the principal researcher is involved in the governance of the clinical learning component of the Bachelor of Nursing program. Also, as the co- coordinator for academic subjects SNUG104 and SNUG108, which are the clinical placement subjects within the 1st year of the Bachelor of Nursing program, the principal researcher will have online contact with student learners, there is no face to face contact for these subjects. From a governance perspective the principal researcher does not have direct control over where or when student learners are placed for their clinical placement however student learners may perceive this differently.

For the clinical supervisor learners the main issue will be to address any feeling of pressure to take part in the research study, as they are a sessional academic staff member employed by the university and hold an annual contract. However, it is important to stress that their relationship with the principal researcher is not a formal managerial one. I am involved in the recruitment and preparation of clinical supervisor learners; therefore, it could be perceived by them that I have influence over their ongoing employment and some related matters such as their allocation of work. This however is not the case.

Feeling pressure to participate

To reduce any feelings of pressure to participate in the research study, several measures have been put in place. As stated earlier in this document, the initial contact for recruitment will be with an independent person. This independent person (the recruiter) will recruit all potential participants. The recruiter is responsible for sending an email (appendix 3) to clinical supervisor learners and student learners inviting them to participate, providing them with an overview of the research study and the access to further verbal and written information. This strategy removes me from the initial recruitment process.

Ongoing relationship nature of participatory research

I will be respectful that participants in this research study will work closely with myself as the principal researcher. Once the group has been formed these issues will be discussed in an open and transparent manner to raise awareness and allow participants the opportunity to provide feedback on the process and their ability to contribute. I will ensure there is a second academic who is not involved in the recruitment or oversight of clinical supervisors or clinical placements present at each of the workshops. This person will open the workshop and introduce the potential issues of feeling pressured to participate and check in during the workshop and at the completion. All discussion related to this will occur in both the student and clinical supervisor learner workshops and with Maria Mackay not present in the room. An independent advisor has been allocated and their contact details are on the participant information form.

All participants will have the option to withdraw from the study at any time. This will be outlined in the participant information and consent forms (Appendixes 1a and 1b) . The initial meeting with all of the participants will reiterate this in person and there will be points throughout the research (at the end of each placement period (August and December 2019) that participants will be invited to consider their ongoing participation in the research and reminded of the ability to withdraw from the study at any time. Becoming a co-researcher will be offered to all participants at the initial meeting. The time consideration and responsibilities will be outlined along with the benefits of being a co-researcher to all participants and they will be informed that their commitment to be a co-researcher is an option not a requirement to participate.

Issues with perceived power

The role of the principal researcher and my role as the Director of Clinical Learning and involvement in the allocation of clinical placements for both student learners and clinical supervisor learners will be explained in the participant information sheet (see appendix 1a) and the initial meeting with the participants. The participants will have information on how to escalate any concerns to the Principal Supervisor and / or the Research office if they feel they are not being addressed or they are uncomfortable with issues or people.

I also have a role as a Subject Co-coordinator for SNUG104 and SNUG108. As I am

the co-coordinator of both subject within this research study, the student learner participants will have their work marked by casual academic staff engaged specifically for marking and any concerns regarding the marks received will be directed to Carley Jans who is the Co-coordinator for both subjects. This information will be provided to participants at the introduction workshop and reinforced at each point we meet. As these students are in their first year of study, they may feel an increased sense of pressure to participate, this is being addressed by all initial email messages being sent by Carley Jans as the Co-coordinator and them having an independent academic to contact, Dr Rebekkah Middleton who is also the Academic Program Director for the Bachelor of Nursing, her details are on the Participant Information Sheet. I will only contact students once they have agreed to participate. I have previously conducted a successful research project in 2018 (approved by UOW ethics committee) which formed the information gathering part of this PhD with 1st year student learners being participants and co-researchers, they reported that their experience was positive and that first year students are ideally situated to participate in future research.

Confidentiality

Only information that is relevant to the purpose of this study will be collected. All participants will be informed that information shared by them and collected by the researcher may be disclosed to other co-researchers. Participants will be enabled to withdraw consent from sharing information that is personal to them. The only exception where a breach of confidentiality may be required is if during any observation or discussion there is information disclosed that highlights issues of concern around risk to the participant or others, or malpractice. As a health professional I have a duty of care to raise issues of concern through appropriate channels in the organisation involved. This will be discussed and highlighted to all participants.

Informed consent to participate

The principal researcher will introduce the PhD research study to the participants (student learners and clinical supervisor learners). All participants will receive an information sheet (appendix 1a) about the research study. There will be an information

session on what is expected from the participants, where the researcher will explain that the participants can contact the principal researcher to discuss the research study and any concerns or questions they may have. There is an information sheet (appendix 1a) which is relevant for each potential participant group in the research study – student learners and clinical supervisor learners. Each group of participants will receive an associated consent form (appendix 1b). The information sheet (appendix 1a) outlines the purpose of the study, why they have been approached to participate, what participation will involve for them, the associated risks and benefits, how confidentiality will be maintained, and what will happen the results of the study. The language used in the information sheets is suitable for a lay person..

All participants will be informed that they will have the right to withdraw or terminate participation of the study at any time. Process consent will be reiterated at each stage of the research and the option to remain or withdraw will be verbally shared with all participants.

Data protection

All data collected will be transferred using remote access onto the QMU G Drive Server via a laptop provided by the University of Wollongong. This locked laptop is password protected, with only the researcher having access using her University of Wollongong and Queen Margaret University username and password. All data collection and storage will be in line with the Data Protection Act 2018.

Private conversations with the participants may be recorded, if consent is given. The digital recorder will be transported in a lockable filing case, which can only be accessed by the principal researcher. The recording device will be stored in a locked filing cabinet within University of Wollongong (Maria Mackay's Office and filing cabinet), which can only be accessed by the researcher. As soon as the recording is transcribed, the recording will be deleted. Quotes from participants will only be used with their consent.

Signed consent forms with the participant's name and signature will be for the

researcher's use only and will not be shared with anyone else or used for any other purpose other than to gain consent. Participants will be given the option to choose a name as a pseudonym to protect their identity.

Participants will be asked if any information could be shared with a colleague of the researcher in a peer review process.

Data analysis

This part of the research is underpinned by the principles of participatory and person-centred research. A very important aspect of participatory research is that the co-researchers within the research study should be involved in all aspects of the research including data analysis. All data analysis will be undertaken by each of the groups (student learners and clinical supervisor learners) separately.

Phase 1 of analysis:

Data analysis will be undertaken with the co-researchers within this PhD research. A process of critical reflection that enables deep listening and quiet still awareness will underpin the analysis of the PhD research findings. The creative reflections and transcribed interviews will be reviewed by the principal researcher and co-researchers. There will be a creative process evaluation that will be undertaken by each of the groups (student learners and clinical supervisor learners) separately. The creative process will be embedded within deep listening where each group will individually and collectively take time to embody the findings through quiet still awareness. This process will have elements of purposeful turbulence where the researcher and co-researchers will hold space within the discomfort of the chaos of the information and use the process of critical reflection to reveal the gems that are located within the data.

Phase 2 of analysis:

Phase 2 data analysis will be undertaken by each of the groups (student learners and clinical supervisor learners) separately. This phase of the study will be underpinned by the principles of authentic participation. The analysis in the part of the PhD research will introduce and test the Model for Person-centred Transformational Learning in

Clinical Practice. In this phase, the findings from part one will be considered and there will be a further step in the data analysis where the researcher and co-researchers will consider how the overall approach to learning across an academic session influences the creation of person-centred learning during a clinical placement.

Data analysis will be a collaborative process and will be a joint activity between the researcher and co-researchers. The influence of deep listening and quiet still awareness will again be embedded in a critical reflective process that enables the gems within the data to emerge.

Dissemination of results

Results will be shared via conference presentations, in peer reviewed journals and through social media.

No funding has been sought for this project

Research team:

Maria Mackay, PhD Candidate, Queen Margaret University

Professor Jan Dewing, Sue Pembrey Chair of Nursing, Director of The Centre for Person-centred Practice Research, Queen Margaret University

Dr Anne Williams, Lecturer, Queen Margaret University

Dr Sharon Bourgeois – Honorary Research Fellow – University of Wollongong, Australia

References:

Australian Nursing and Midwifery Accreditation Council (ANMAC)., 2012. *Registered Nurse Accreditation Standards 2012*. Canberra ACT: Australian Nursing and Midwifery Accreditation Council.

BAUM, F., MACDOUGALL, C., and SMITH, D., 2006. Participatory Action Research. *Journal of Epidemiol Community Health*. vol. 60, pp. 854-857.

BEVAN, A.L., 2013. *Creating communicative spaces in an action research study. Nurse Researcher*. vol. 21, no. 2, pp. 14-17.

BHASKAR, R.A. and HARTWIG, M., 2010. *The Formation of Critical Realism: A personal perspective.* New York: Routledge.

CELL PRESS. 2017. "Why scientists should research emojis and emoticons :-P". *ScienceDaily*. Viewed: 17 January 2017, Available from: www.sciencedaily.com/releases/2017/01/170117140140.htm.

COHEN, L., MANION, L. and MORRISON, K., 2018. *Research methods in Education*. 8th ed., Abingdon; OXAN: Routledge.

GIDDENS, J.F. and EDDY, L., 2009. A survey of physical examination skills taught in undergraduate nursing programs: are we teaching too much? *Journal of Nursing Education*. vol. 48, no. 1, pp. 24-29.

HABERMAS, J., 1981. *The Theory of Communicative Action*. Great Britain: MIT Press.

Health Education and Training Institute, (HETI)., 2013. T*he Superguide: a Supervision Continuum for Nurses and Midwives.* Health Education and Training Institute. Available from: http://www.heti.nsw.gov.au/Resources-Library/Nursing-Midwifery-Superguide/.

LEVETT-JONES, T. and LATHLEAN, J., 2007. Belongingness: A montage of nursing students' stories of their clinical placement experiences. *Contemporary Nurse*. vol. 24, no. 2, pp. 162-174.

LEVETT-JONES, T., LATHLEAN, J., HIGGINS, I. and MCMILLAN, M., 2009. Staff - Student relationships and their impact on nursing students' belongingness and learning. *Journal of Advanced Nursing*. vol. 65, no. 2, pp. 316-324.

MACKAY, M., T., BROWN, R., A., JOYCE-MCCOACH, J. and SMITH, K., M., 2014. The development of a model of education for casual academic staff who support nursing students in practice. *Nurse Education in Practice*. 05, vol. 14, no. 3, pp. 281-285.

McCormack, B. and McCance, T., ed. 2017. *Person-Centred practice in nursing and health care: Theory and practice*. United States: John Wiley & Sons.

MCCORMACK, B., DEWING, J., and MCCANCE, T., 2011. Developing person-centred care: addressing contextual challenges through practice development. [Online] Journal of Issues in Nursing. Vol. 16, no. 2. Available: https://ro.uow.edu.au/smhpapers/2471/

MCKINNON, J., 2009. Tomorrow's nurse graduate, today: the change in undergraduate education. *British Journal of Nursing*, vol. 18, no. 16, pp. 986-989.

MCNIFF, J. and WHITEHEAD, J., eds., 2011. *All You Need to Know About Action Research*. 2nd ed. London, UK: SAGE Publication.

UNGUNMERR-BAUMANN, M., 2015. *DADIRRI, Inner Deep Listening and Quiet Still Awareness*. Available from: http://nextwave.org.au/wp-content/uploads/Dadirri-Inner-Deep-Listening-M-R-Ungunmerr-Bauman-Refl.pdf.

VINALES, J. J., 2015. The mentor as a role model and the importance of belongingness. *British Journal of Nursing.* vol. 24, no. 10, pp. 532-535. .

Ethics Approval

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24 May 2019

Dear Maria,

Ethical Approval – Crafting person-centred learning relationships for clinical supervisor learners and student learners: participatory person-centred research

Thank you for submitting your application for ethical approval of this study. I can confirm that QMU has granted full ethical approval for your research.

A standard condition of this ethical approval is that you are required to notify the Panel, in advance, of any significant proposed deviation from the original protocol. Reports to the Committee are also required once the research is underway if there are any unexpected results or events that raise questions about the safety of the research

We would like to wish you well with your project.

Yours sincerely

Lucy Hinds
Secretary to the Research Ethics Panel

DIVISION OF GOVERNANCE AND QUALITY ENHANCEMENT
QUEEN MARGARET UNIVERSITY, EDINBURGH
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EAST LOTHIAN EH21 6UU
TELEPHONE: 0131 474 0000

From: irma-support@uow.edu.au
To: Maria Mackay
Cc: Maria Mackay; RSO Ethics
Subject: Externally Approved Ethics Application 2019/237
Date: Wednesday, 3 July 2019 10:31:00 AM

Dear Mrs Mackay,

Thank you for submitting a copy of your Ethics Application for 'Crafting person-centred learning relationships for clinical supervisor learners and student learners: participatory person-centred research'.

UOW accepts the approval by Queen Margaret University HREC. The approving HREC is responsible for monitoring. Annual reporting to UOW is not required, however, you are required to notify the RSO Ethics Unit of any complaints or adverse events that could affect the ongoing acceptability of the project.

If you have any questions regarding this submission, please contact the Research Ethics team by phone on 4221 3386, or by email at rso-ethics@uow.edu.au.

Yours sincerely,

Research Ethics Team

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http://www.uow.edu.au/research/ethics

Appendix R

Recruitment Email for co-researchers in part two – example

Thank you for participating in for the emoji information collection in part one of this research project. We are now moving to round two and are inviting you to join us in this part of the research as a co-researcher.

You are receiving this email to invite you to attend a workshop to make sense of the information that was collected Throughout the whole research project (round one and round two).

All the other students / clinical supervisors who have aprticpated in the research to date will also receive this email. If you choose to participate as a co-researcher we would ask you to take part for approximately a total of 2 hour workshop that will be facilitated by Maria Mackay as the principal researcher and one other academic staff member. You will be asked to review the information collected prior to the workshop. During the workshop we will be using creative methods to help you make sense of the information we collected in part one and see how this influences person-centred transformational learning in clinical practice..

Your participation in this study is not a requirement of your enrolment / employment at the University of Wollongong, there is no payment for participation, and your decision to participate or not will not affect your enrolment / employment or clinical placement allocation at the University of Wollongong.

Included within this email is a participant information sheet to remind you of the study research project and give you more details of the research that will provide you further information and allow you to further consider your participation as a co-researcher in this research. If you would like to take part in the research study please reply to this email on cjans@uow.edu.au and you will be sent a consent form via email for you to complete.

In the meantime if you would prefer to talk to someone about the project please contact: Carly Jans on 42213219 or email cjans@uow.edu.au or Maria Mackay Principal Researcher on ph.0407369627 or email mmackay@uow.edu.au .

Carley Jans

Lecturer – School of Nursing

Appendix S

Pathway to Impact Plan

Impact Summary Statement(s):

This impact plans aims to disseminate the outputs from Maria Mackay PhD research. The sharing of the outputs is aimed locally, nationally, and internationally. The target audience are researchers who are interested in developing innovative, creative, person-centred pre-registration nursing curricula, nursing academic staff and nursing students.

Issue	Stakeholder	Activities that actively engage relevant stakeholders/publics;	Timelines	Progress
To communicate a person-centred guideline for facilitating learning in practice for pre-registration nursing students locally and internationally.	UOW School of Nursing academic staff and students (Australia) ICOP QMU School of Nursing (UK) Queens School of nursing (Canada)	Develop face to face and online modules for implementation of guidelines to UOW clinical supervisors Implementation of updated guideline at UOW Send updated guideline and summary to ICoP to be placed on website. Engage with staff at QMU and Queens University to share updated guidelines Publication (Enabling the voice of nursing students in designing an educational resource for their preparation to participate in the reality of clinical practice.) with student co-researchers in the Journal of Professional Nursing Studies.	February 21 March 2021 January 2021 February 2021 2020	Guideline has been implemented and evaluated at UOW School of nursing. Updated version of guideline now completed Implementation of updated guidelines in 2021 at UOW Student- led conversation form implements at UOW (approx 1500 students) Education modules developed for UOW clinical supervisors inline with guidelines and implemented in 2020. Publication submitted October 2020

Issue	Stakeholder	Activities that actively engage relevant stakeholders/publics;	Timelines	Progress
To add to what is currently known about the use of emoji as a research tool in health education research	Person-centred researchers Health education researchers	Publication in Contemporary Nurse : How do emoji facilitate learners within the context of health education research? Conference presentation at NNEC Education conference 2021 (Australia / New Zealand focus) Gold Coast NSW.	October 2020 Sept 2021	Publication submitted October 2020 Abstract Due Monday 11 January 2021
To Challenge current curriculum for pre-registration nursing to embrace a person-centred learning in the practice context.	Person-centred education researchers Nursing academic staff Nursing students	Publication in IPDJ – crafting healthful relationships Publication in Collegian The theoretical framework for person-centred learning in the practice context. Conference presentation at NETNEP 2022	June 2021 Nov 2021 TBA	Date and location not known due to COVID19 delays for international conferences

Issue	**Stakeholder**	**Activities that actively engage relevant stakeholders/publics;**	**Timelines**	**Progress**
To contribute to the conversation nationally and internationally regarding the decolonisation of pre-registration nursing curriculum	Person-centred education researchers Researchers interested in decolonisation of curriculum Nursing academic staff Nursing students	Conference presentation at European Sigma conference 2022 Conference presentation at Congress of Aboriginal and Torres Strait Islander Nurses and Midwives conference 2021 Publication on knowing self to enable belonging Nurse Education today	TBA 12-14 April 2021 Cairns QLD Australia Sept 2021	Due to COVID19 travels delays from Australia, I am unable to attend international conferences until 2022

Issue	Stakeholder	Activities that actively engage relevant stakeholders/publics;	Timelines	Progress
To continue connection with the International Community of Person Centred Practice	QMU Centre for Person-centred Practice Research	Continue to be an affiliated member of the QMU Centre for Person-Centred Practice Research Seek membership of the International Community of Practice for person-centred practice (PcP-ICoP)	2021 onwards	Maintain connection with researchers who are actively engaged in person-centred research